

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

001 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

See: Birth Cert. at

Reg. Dist. No.

00003

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b Lifetime	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL**DOA		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Edward C. Athey Jr.		4. DATE OF DEATH January 13 19 60	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 6, 1958
9. AGE (In years last birthday) 2 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Cumberland, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward C. Athey		14. MOTHER'S MAIDEN NAME Dixie Lee Klosterman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Edward C. Athey Sr.		Address Creek Road	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Meningitis DUE TO Streptococcus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Streptococcus DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1-2 Days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Benedict Skitarelic		DATE SIGNED	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Jan. 14, 1961	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF I-16-61	22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park	22d. LOCATION (City, town, or county) (State) Cumberland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR JAN 17 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

STATE OF TEXAS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED JAMES EARL RAY		AGE 35		SEX Male		RACE White	
DATE OF DEATH April 4, 1968		PLACE OF DEATH Memphis, Tennessee		CITY Memphis		COUNTY Shelby	
OCCUPATION Attorney		EDUCATION Bachelor's Degree		MARRIAGE Married		SINGLE	
CAUSE OF DEATH Suicide		MANNER OF DEATH Homicide		IMMEDIATE CAUSE Shot		UNDERLYING CAUSE Depression	
SIGNS AND SYMPTOMS None		POSTMORTEM FINDINGS None		TOXICOLOGY None		LABORATORY TESTS None	
SIGNATURE OF EXAMINER [Signature]		DATE April 4, 1968		PLACE Memphis, Tennessee		COUNTY Shelby	
STATE OF TEXAS		COUNTY OF SHELBY		CITY OF MEMPHIS		JAMES EARL RAY	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 002 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00004

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Flintstone</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>				d. STREET ADDRESS <u>Route 2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ALBERT</u> Middle <u>EUGENE</u> Last <u>BENNETT</u>				4. DATE OF DEATH Month <u>January</u> Day <u>30</u> Year <u>1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 24, 1937</u>		9. AGE (In years last birthday) <u>23</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>M. P. Military Service</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>(discharged Sept. 60)</u>		11. BIRTHPLACE (State or foreign country) <u>Chaneysville, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Coyle Dayton Bennett</u>				14. MOTHER'S MAIDEN NAME <u>Myrtle Agnes Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>1957-1960</u>		17. INFORMANT <u>Coyle Bennett, father, Flintstone, Rt. 2, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure; hydrothorax; ascites</u> DUE TO 590X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Acute glomerulonephritis</u> DUE TO (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>2-3 days</u> <u>1-2 wks.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>BENEDICT SKITARELIC</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 1, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glendale Brethren Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Flintstone, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hofer</u>				ADDRESS <u>Cumberland, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 3 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for a burial, cremation, or removal.

STATE OF TEXAS, COUNTY OF DALLAS, DECEMBER 1, 1901.

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00005

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 17 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL WARWICK & MEMORIAL AVENUES				d. STREET ADDRESS 328 RESERVOIR AVE.,			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First JOSEPH Middle R. Last BISHOP				4. DATE OF DEATH Month JANUARY Day 12, Year 1961.			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 28, 1884	
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months 76 Days 76 Hours 76 Min.		IF UNDER 24 HRS. Months 76 Days 76 Hours 76 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Truckman				10b. KIND OF BUSINESS OR INDUSTRY B+O Railroad			
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME NATHAN BISHOP				14. MOTHER'S MAIDEN NAME HESTER ANN ASKROCK ASKEY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. MEMORIAL HOSPITAL - CUMBERLAND, MD.			
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 450.0 IMMEDIATE CAUSE (a) 450.0 DUE TO Chorea Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Paralytic Pleuro (c) Arteriosclerosis				INTERVAL BETWEEN ONSET AND DEATH 3 wks 2 wks 10 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Jan 10 1961 to Jan 12 1961 , that (I) (we) last saw the deceased alive on Jan 11 1961 , and that death occurred at 2:55 PM from the causes and on the date stated above.							
22a. SIGNATURE Clay E. Durrett				22b. DATE SIGNED Jan 12 1961			
22c. PHYSICIAN'S NAME (Type) DR. CLAY E. DURRETT				22d. ADDRESS 236 VIRGINIA AVE., CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Jan 15, 1961			
23c. NAME OF CEMETERY OR CREMATORY Oliver Grove Meth. Cem.				23d. LOCATION (City, town, or county) (State) Near Oldtown Md			
24. FUNERAL DIRECTOR'S SIGNATURE John F. Hafer				25a. REC'D BY REGISTRAR Arthur S. Kline			
ADDRESS Cumberland, Md.				25b. REGISTRAR'S SIGNATURE Arthur S. Kline			
DATE JAN 16 '61							

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CERTIFICATE OF DEATH

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ALLEGANY

TOWNSHIP

ALLEGANY

CHURCH

17 DAYS

CUMBERLAND

WATSON & MEMORIAL AVENUE

350 RESERVOIR AVE.

JOSEPH

ELIHOPE

JANUARY 12, 1901

WHITE

1850

RECEIVED

NATION BIRD

1850

MEMORIAL HOSPITAL - CUMBERLAND, MD.

CUMBERLAND

DR. CLAY C. BURDET

350 VIRGINIA AVE., CUMBERLAND, MD.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

004

CERTIFICATE OF DEATH

00006

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MARYLAND			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MARYLAND		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First LYNN Middle ABNER Last BISHOP			4. DATE OF DEATH Month JANUARY Day 1 Year 1961		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-2-1911		9. AGE (In years last birthday) 49 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Trucker (C.A) Dept		10b. KIND OF BUSINESS OR INDUSTRY Textile Mill	11. BIRTHPLACE (County & State, or foreign country) WEST VIRGINIA, Oldtown		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME ABNER BISHOP			14. MOTHER'S MAIDEN NAME EDITH ARNOLD		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. 217-10-7577	17. INFORMANT MEMORIAL HOSPITAL CUMBERLAND, MARYLAND		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-sclerotic Heart Disease DUE TO (c) unknown					INTERVAL BETWEEN ONSET AND DEATH 4 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from Jan 1, 1961 to Jan 1, 1961 , that (I) (we) last saw the deceased alive on Jan 1, 1961 , and that death occurred at 12:25 PM from the causes and on the date stated above.					
22a. SIGNATURE L. Michael Glick M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) L. Michael Glick		22d. ADDRESS 126 N. Smallwood Street, Cumberland, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF I-4-61	23c. NAME OF CEMETERY OR CREMATORY Mt. Tabor Cem.	23d. LOCATION (City, town or county) (State) Cumberland, Md.		
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		ADDRESS Cumberland, Md.		25a. REC'D BY REGISTRAR JAN 4 '61	25b. REGISTRAR'S SIGNATURE Arthur L. Frank

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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ALLEGANY

WYOMING

WYOMING, WYOMING

2 DAYS

WYOMING, WYOMING

ROUTE 1, BOX 312

HOSPITAL

1 JANUARY 1951

BISHOP

ABER

LYNN

19

1-2-1911

X

WHITE

WIFE

WEST VIRGINIA DISTRICT

Trucker (C.A.) Dept Textile Mill

WITH ARRIVAL

ABER BISHOP

217-10-7527 HOSPITAL HOSPITAL WYOMING

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Cambridge, N.Y.

1-4-61 Mr. F. for Gen.

Mr. W. J. ...

James F. Scott ...

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 1/11/61		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland 02			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary				d. STREET ADDRESS 434 Williams Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Jennie Middle M. Last Brown				4. DATE OF DEATH Month January Day 20 , Year 1961			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/15/1871		9. AGE (In years last birthday) 90 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Lonaconing, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Daniel Stuart				14. MOTHER'S MAIDEN NAME Jane Young			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) NONE		17. INFORMANT P. O. Box 599 Address Cumberland, Md. Allegany County Infirmary records.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Hypertosis 422.2 DUE TO Chronic Myocardial Degeneration Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Cerebral arteriosclerosis. (c) ?							INTERVAL BETWEEN ONSET AND DEATH 48 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Severe Detrimoration.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/11/61 19 to 1/20/61 19, that (I) (we) last saw the deceased alive on 1/19/61 19, and that death occurred at 11:45 A.M. M, from the causes and on the date stated above.							
22a. SIGNATURE James E. McLean M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 1/20/61	
22c. PHYSICIAN'S NAME (Type) Dr. James E. McLean				22d. ADDRESS 49 Greene St., Cumberland, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/22/61		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City, town, or county) (State) Cumberland Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox				25a. REC'D BY REGISTRAR Cumberland Maryland		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

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CERTIFICATE OF DEATH

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

006

00008

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg,				c. LENGTH OF STAY IN 1b 17 Yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 119 Centennial St. Extd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle E. Last Byrnes				4. DATE OF DEATH Month January Day 4th , Year 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 1st, 1878	
9. AGE (In years last birthday) 82 yrs.		10. UNDER 1 YEAR Months 82		11. UNDER 24 HRS. Days 82 Hours 82 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own housework		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME John W. Grimes				14. MOTHER'S MAIDEN NAME Margaret Shea			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None				16. SOCIAL SECURITY NO. None			
17. INFORMANT Mrs. Anna Robinson				18. ADDRESS 121 Centennial St. Frostburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arterio-sclerotic cardiac - DUE TO vascular disease. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 422.1 (c) 422.1 INTERVAL BETWEEN ONSET AND DEATH 4 years.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Serility							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 10-1 19 59 to 1-4 19 61 , that (I) (we) last saw the deceased alive on 1-4 19 61 , and that death occurred at 11 A.M. from the causes and on the date stated above.							
22a. SIGNATURE H. C. Diehl,				22b. DATE SIGNED 1/6/61			
22c. PHYSICIAN'S NAME (Type) H. C. Diehl,				22d. ADDRESS 39 W. Main St., Frostburg, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-7-61		23c. NAME OF CEMETERY OR CREMATORY St. Michael's Cemetery		23d. LOCATION (City, town, or county) (State) Frostburg, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE J. P. Burst				ADDRESS Frostburg, Md.		25a. REC'D BY REGISTRAR DATE 9 '61	
				25b. REGISTRAR'S SIGNATURE Arthur E. Hines			

MEDICAL CERTIFICATION

22

1503 2 6

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

007

CERTIFICATE OF DEATH

00009

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 5 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 506 Decatur Street				d. STREET ADDRESS 506 Decatur Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Elwood Middle John Last Cannon				4. DATE OF DEATH Month January Day 28 Year 19 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Nov 13, 1908	
9. AGE (In years lost birthday) 52 yrs.		IF UNDER 1 YEAR Months 52 Days 52 Hours 52 Min. 52		IF UNDER 24 HRS. Months 52 Days 52 Hours 52 Min. 52			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Army service		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Otto Cannon				14. MOTHER'S MAIDEN NAME Blanche Lease			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. 214-26-8068		17. INFORMANT Mrs. Richard Lowman	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 1/28 , 19 61 , to 1/28 , 19 61 , that (I) (we) last saw the deceased alive on 1/28 , 19 61 , and that death occurred at 9 AM , from the causes and on the date stated above.							
22a. SIGNATURE Leo H. Ley Jr.				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1/30/61	
22c. PHYSICIAN'S NAME (Type) LEO H. LEY JR. MD.				22d. ADDRESS 452 N. Centre St. Cumberland Ind.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/2/61		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery Arlington		23d. LOCATION (City, town, or county) (State) Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox				ADDRESS Cumberland Maryland		25a. REC'D BY REGISTRAR FEB 1 '61	
				25b. REGISTRAR'S SIGNATURE Charles S. Hines			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

008 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00010

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,			c. LENGTH OF STAY IN 1b 17 hrs.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 32 Cumberland,	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hosp.				d. STREET ADDRESS 304 N. Waverly Terrace			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First GILBERT Middle WILLIAM Last COLE				4. DATE OF DEATH Month Jan. Day 17, Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 26, 1907	
				9. AGE (In years last birthday) 53 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Prop. & Owner				10b. KIND OF BUSINESS OR INDUSTRY Meat Market		11. BIRTHPLACE (State or foreign country) Bolivar, W. Va.	
						12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John W. Cole				14. MOTHER'S MAIDEN NAME Alice A. McCormick			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No,		16. SOCIAL SECURITY NO. 214-05-5208		17. INFORMANT Mrs. Ruth E. Cole, 304 N. Waverly Terrace			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC TAMPONADE							
DUE TO 451X							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
(b) RUPTURED DISSECTING ANEURYSM OF AORTA							
DUE TO							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Benedict Skitarelic				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> JANUARY 17, 1961			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/20/61		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR JAN 23 '61	
						24b. REGISTRAR'S SIGNATURE <i>Arthur L. Harris</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
009					CERTIFICATE OF DEATH				
00011									
1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland, c. LENGTH OF STAY IN 1b 64yrs d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 308 Pennsylvania Ave					2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland, d. STREET ADDRESS 308 Pennsylvania Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Emma Lena Collins					4. DATE OF DEATH Jan. 17, 1961				
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 27, 1882		9. AGE (In years last birthday) 78 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Ownhome		11. BIRTHPLACE (County & State, or foreign country) Artemas, Pa.		12. CITIZEN OF WHAT COUNTRY? USA		IF UNDER 1 YEAR Months Days Hours Min.	
13. FATHER'S NAME Jacob Potts					14. MOTHER'S MAIDEN NAME Arthelia Goodrich				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Richard J. Collins Address 308 Pa. Ave.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio Sclerotic Vascular Disease 260X DUE TO Conditions, if any, which gave rise to immediate cause (b) Advanced causing the underlying (c) Diabetes Mellitus cause last. Since 1935 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None INTERVAL BETWEEN ONSET AND DEATH Since 1950									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1-1-1961 to 1-17-61 that (I) (we) last saw the deceased alive on 1-16-61 and that death occurred at 2:15P from the causes and on the date stated above.									
22a. SIGNATURE W.F. Williams M.D.					22b. DATE SIGNED 1-18-61				
22c. PHYSICIAN'S NAME (Type) W.F. Williams					22d. ADDRESS 122 S Centre St. Cumberland, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF I-20-61		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cem.		23d. LOCATION (City, town or county) (State) Cumberland, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli ADDRESS Cumberland, Md.					25a. REC'D BY REGISTRAR JAN 24 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kline		

00011

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Allegany

Allegany

Allegany

Chamberland, Mo.

Days

Chamberland, Mo.

306 Pennsylvania Ave

306 Pennsylvania Ave

Collins

Leah

Leah

Jan. 19, 81

Dec. 27, 1882

USA

Artemis, Pa.

Artemis

Artemis

Artemis Goodrich

Jacob Fotta

Richard J. Collins 306 Pa. Ave.

None

None

1

[Handwritten signatures and notes, including "Richard J. Collins" and "Jacob Fotta"]

1-1-81

[Handwritten notes and signatures]

125 N Centre St. Chamberland, Mo.

W.F. Williams

Chamberland, Mo.

Rose Hill Cem.

Barrel 1-20-81

Chamberland, Mo.

Chamberland, Mo.

James J. Son, call

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

010

CERTIFICATE OF DEATH

05005

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 13 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If in hospital, give street address) MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROUTE #4, CUMBERLAND, MD. d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) RONALD ROY COOK		4. DATE OF DEATH Month JANUARY Day 31 Year 1961	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 30, 1947
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY Grade school	9. AGE (In years last birthday) 13 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MD.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME CLYDE DAYTON COOK		14. MOTHER'S MAIDEN NAME FRANCES GROVE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT MEMORIAL HOSPITAL-CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 173.0 Corebellar Tumor - Carcinoma DUE TO (b) 173.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Meningeal Lymphoma		INTERVAL BETWEEN ONSET AND DEATH 14 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan 31, 1961 to Jan 31, 1961 , that (I) (we) last saw the deceased alive on Jan 31, 1961 , and that death occurred at 3:00 P.M. from the causes and on the date stated above.			
22a. SIGNATURE [Signature]		22b. DATE SIGNED 2/2/61	
22c. PHYSICIAN'S NAME (Type) DR. G. O. HIMMELWRIGHT		22d. ADDRESS 133 VIRGINIA AVENUE	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2-3-61	23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park	23d. LOCATION (City, town or county) (State) Cumberland Md.
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpetti		25a. REC'D BY REGISTRAR FEB 9 '61	
ADDRESS Cumberland, Md.		25b. REGISTRAR'S SIGNATURE Arthur L. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

02002

070

ALLERGY

WRYLAND

ALLERGY

STATE IN, CURELAND, NO.

15 DAYS

CURELAND

MEMORIAL HOSPITAL

MEMORIAL I. MARSH AVE.

JANUARY 31

COOK

ROY

RONALD

JULY 30, 1947

WHITE

WILE

U. S. A.

CURELAND, NO.

GRADE SCHOOL

RECEIVED

FR. HESS GROVE

CLOYE DAYTON CREEK

I

MEMORIAL HOSPITAL-CURELAND, NO.

JOHN

183 VIRGINIA AVENUE

DR. G. C. HUMPHREY

MEMORIAL HOSPITAL, CURELAND, NO.

183 VIRGINIA AVENUE

James A. Southern Co. Portland, ME.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

011

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00012

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MARYLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MARYLAND			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL				d. STREET ADDRESS 624 N. CENTRE STREET			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First ELLA Middle MAE Last COUGHENOUR				4. DATE OF DEATH Month 1 Day 15 Year 61			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/18/85	
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) PA.	
12. CITIZEN OF WHAT COUNTRY? UNITED STATE							
13. FATHER'S NAME Albert Glesner				14. MOTHER'S MAIDEN NAME DELLA GLESNER XXXX (D)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Lee Moyer Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary heart disease DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Urinary infection, pyelonephritis osteoarthritis 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1950 to 1/15 1961 , that (I) (we) last saw the deceased alive on 1/14 1961 , and that death occurred at 8:00 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Elizabeth Briggs				22b. DATE SIGNED 1/15/61			
22c. PHYSICIAN'S NAME (Type) DR. E. BRINGS				22d. ADDRESS 55 Green St. Cumberland, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 18, 1961		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Byron Kight				ADDRESS Cumberland, Md.		25a. REC'D BY REGISTRAR DATE JAN 17 '61	
						25b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

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may be required by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DR. BALLIN

012

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00013

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 14 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS 633 HILL TOP DRIVE			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First WALTER Middle Paul Last CRABTREE				4. DATE OF DEATH Month JANUARY Day 17 Year 1961			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1892		9. AGE (In years last birthday) 68 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Police Officer				10b. KIND OF BUSINESS OR INDUSTRY City Police Dept.		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME LEONARD CRABTREE				14. MOTHER'S MAIDEN NAME FANNIE OGDEN MEYERS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. W.W. 1			
17. INFORMANT MEMORIAL HOSPITAL & CUMBERLAND, MD.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident 422.1 DUE TO Arteriosclerotic cardio-vascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 2 mos DUE TO 2 years (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 3 13 19 55 to 1 - 17 19 61 , that (I) (we) last saw the deceased alive on 1 - 16 19 61 , and that death occurred at 2:47 A.M. the causes and on the date stated above.							
22a. SIGNATURE Ralph W. Ballin				22b. DATE SIGNED 1-17-61			
22c. PHYSICIAN'S NAME (Type) DR. RALPH W. BALLIN				22d. ADDRESS 62 GREENE ST., CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 1/20/61			
23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park				23d. LOCATION (City, town, or county) (State) Cumberland, Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland				25a. REC'D BY REGISTRAR JAN 23 '61			
				25b. REGISTRAR'S SIGNATURE William L. Hume			

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 17 1/2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JAMES Middle ERNEST Last CRAMER				4. DATE OF DEATH Month JANUARY Day 6 Year 1961			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-15-1898	
9. AGE (In years last birthday) 62 1/2 yrs.		IF UNDER 1 YEAR Months 6 Days 2 Hours 0 Min. 0		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CAR INSPECTOR				10b. KIND OF BUSINESS OR INDUSTRY Western Md. RR.		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME WILLIAM F. CRAMER				14. MOTHER'S MAIDEN NAME CLARA BENNER CRAMER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address Md. Mrs. James Cramer 212 S. Lee St. Cumb.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident DUE TO 4-22-1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardio-vascular disease DUE TO 4 years (c) 16 days PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I (a) Rheumatoid Arthritis 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 1-20-1957 to 1-6-1961 , that (I) (we) lost the deceased alive on 1-5-1961 and that death occurred at 5 AM , from the causes and on the date stated above.							
22a. SIGNATURE Ralph B. Ballin				22b. DATE SIGNED 1-6-61			
22c. PHYSICIAN'S NAME (Type) DR. RALPH BALLIN, M.D.				22d. ADDRESS 62 Greene St. Cumberland, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 8 1961		23c. NAME OF CEMETERY OR CREMATORY Mountain View Cem.		23d. LOCATION (City, town, or county) (State) Sharpsburg, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George, Cumberland, Md.				25a. REC'D BY REGISTRAR JAN 9 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kane	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
014 **CERTIFICATE OF DEATH** **00015**

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART				d. STREET ADDRESS 1 16 WILLISON PLACE			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES FLOYD DAVIS				4. DATE OF DEATH Month Day Year JANUARY 7, 1961			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 3, 1900		9. AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED Brakeman		10b. KIND OF BUSINESS OR INDUSTRY B & O RAILROAD		11. BIRTHPLACE (State or foreign country) Oldtown, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES DAVIS				14. MOTHER'S MAIDEN NAME Nellie V. Twigg			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No,		16. SOCIAL SECURITY NO.		17. INFORMANT Address Richard H. Davis 22 Va. Ave., Cumb. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure 502.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pulmonary Emphysema DUE TO (c) Bronchectasis							INTERVAL BETWEEN ONSET AND DEATH 4 days unknown unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchopneumonia							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5 Jan 1961 to 7 Jan 1961 , that (I) (we) last saw the deceased alive on 7 Jan 1961 , and that death occurred at 1:30 P.M. from the causes and on the date stated above.							
22a. SIGNATURE L. Michael Glick M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1/8/61	
22c. PHYSICIAN'S NAME (Type) L. MICHAEL GLICK				22d. ADDRESS 126 N. SMALLWOOD St. CUMBERLAND MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/10/61		23c. NAME OF CEMETERY OR CREMATORY Zion Memorial Cemetery		23d. LOCATION (City, town, or county) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George				ADDRESS Cumberland, Md.		25a. REC'D BY REGISTRAR JAN 10 '61	
				25b. REGISTRAR'S SIGNATURE Robert S. Thomas			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 11 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL AND WARWICK AVES.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GARNET Middle W. Last DAVIS		4. DATE OF DEATH Month JANUARY Day 12 Year 19 61	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JANUARY 5, 1906
9. AGE (In years last birthday) 55 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) President		10b. KIND OF BUSINESS OR INDUSTRY Neon Sign Company	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME THOMAS DAVIS		14. MOTHER'S MAIDEN NAME NORA WILSON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214 05 5670	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Congestive Heart Failure 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Atherosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pericardial effusion		INTERVAL BETWEEN ONSET AND DEATH 3 wks. 1-2 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 7:41 P.M. 1961 , that (I) (we) last saw the deceased alive on 1-13 1961 , and that death occurred at M. from the causes and on the date stated above.			
22a. SIGNATURE William P. James		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) DR. W. P. JAMES		22d. ADDRESS 441 N. CENTRE ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 15, 1961	
23c. NAME OF CEMETERY OR CREMATORY Mt. Tabor Cemetery		23d. LOCATION (City, town, or county) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Byron Knight		25a. REC'D BY REGISTRAR DATE JAN 17 '61	
ADDRESS Cumberland, Md.		25b. REGISTRAR'S SIGNATURE Arthur L. Harris	

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THOMAS DAVID

MARY WILSON

MENTAL HOSPITAL - CINCINNATI, OHIO

DR. H. C. GENTLE, JR., CINCINNATI, OH.

DR. H. C. GENTLE, JR., CINCINNATI, OH.

00017

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg,</u>	
c. LENGTH OF STAY IN 1b <u>1 hour</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sacred Heart Hospital</u>		d. STREET ADDRESS <u>192 West Main St.</u>	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
	Henry	Bernard	Davis		Jan-	13	1961

5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Sept. 5, 1900	9. AGE (in years last birthday) 60 yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.	
					Months	Days	Hours	Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hosteler	10b. KIND OF BUSINESS OR INDUSTRY Race track	11. BIRTHPLACE (State or foreign country) Pennsylvania	12. CITIZEN OF WHAT COUNTRY? USA
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13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Henry Quaster	Jennie Skelton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. 211-05-8298	17. INFORMANT Mrs. Minnie Grant, Frostburg, Md.	Address 192 W. Main Street
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	CORONARY OCCLUSION	1 Hour
420.1 DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	CORONARY SCLEROSIS	
DUE TO		
(c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)	19. WAS AUTOPSY PERFORMED?
	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY		Month, Day, Year	20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
Hour	a. m. p. m.	19	While of work <input type="checkbox"/>	Not while of work <input type="checkbox"/>				

21. I **certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE Benedict Skitarellic M.D. CHIEF MEDICAL EXAMINER ☐ DATE SIGNED
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D. ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒ JANUARY 13, 1960

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-15-61	22c. NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park	22d. LOCATION (City, town, or county) Frostburg,	(State) Md.
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23. FUNERAL DIRECTOR'S SIGNATURE <i>E. R. Durst</i>	ADDRESS Frostburg, Md.	24a. REC'D BY REGISTRAR DATE JAN 17 '61	24b. REGISTRAR'S SIGNATURE <i>William L. Kraus</i>
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

017 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

C0018

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			c. LENGTH OF STAY IN 1b <u>58 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>01 Cumberland</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>211 Grand Ave.</u>				d. STREET ADDRESS <u>211 Grand Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Stella F. Deering</u>				4. DATE OF DEATH Month Day Year <u>Jan. 2 1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <u>March 6, 1884</u>		9. AGE (In years last birthday) <u>76</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Buckvalley, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William P. Lashley</u>				14. MOTHER'S MAIDEN NAME <u>Harriett Northcraft</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Miss Olive Deering, Cumberland, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <u>CORONARY SCLEROSIS</u> (c) </div> <div style="width: 15%;"> INTERVAL BETWEEN ONSET AND DEATH <u>SUDDN</u> <u>*--</u> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Benedict Skitarelic, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Jan. 2, 1961</u>				DATE SIGNED			
22a. BURIAL, CREMATION, REBURY (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-5-1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>			
22d. LOCATION (City, town, or county) <u>Cumberland, Md.</u>		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli, Cumberland, Md.</u>				24a. REC'D BY REGISTRAR <u>JAN 4 '61</u>			
ADDRESS				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Knaus</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. For burial, cremation, or removal, TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

1
018 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00019

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. LENGTH OF STAY IN 1b 3 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MINERS HOSPITAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 22 FROSTBURG	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS 18 1/2 CENTENNIAL ST.	
3. NAME OF DECEASED (Type or print) First GRANT Middle U. Last DEIBLER		4. DATE OF DEATH Month JANUARY Day 27 , Year 1961	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 18, 1874
9. AGE (In years last birthday) 86		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED FARMER		10b. KIND OF BUSINESS OR INDUSTRY OWN FARM	
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME OBED DEIBLER		14. MOTHER'S MAIDEN NAME LYDIA BOWERS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NONE		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MRS. FRANCIS CUNNINGHAM, FROSTBURG, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastro-enteritis Viral 571.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Terminal Pneumonia		INTERVAL BETWEEN ONSET AND DEATH 10 days	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) X	
20c. TIME OF INJURY Month, Day, Year Hour a. m. X 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) X		20f. (City or town) (County) (State) X	
21. I certify that (I) (this hospital) attended the deceased from 1/21 19 61 , to JAN 27 19 61 , that (I) (we) last saw the deceased alive on 1/27 19 61 , and that death occurred at 4:30 M, from the causes and on the date stated above.			
22a. SIGNATURE Martin Rothstein MD		22b. DATE SIGNED 1/27/61	
22c. PHYSICIAN'S NAME (Type) MARTIN ROTHSTEIN, M. D.		22d. ADDRESS 48 BROADWAY, FROSTBURG, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1-30-1961	
23c. NAME OF CEMETERY OR CREMATORY ST. MICHAEL'S CEMETERY		23d. LOCATION (City, town, or county) (State) FROSTBURG, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE J. R. Burt		25a. REC'D BY REGISTRAR DATE JAN 30 '61	
ADDRESS FROSTBURG, MD.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

018

00019

ALL COUNTY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

019

CERTIFICATE OF DEATH

Item 7, Film G-285 4/27/61.cac.

00022

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYATTSVILLE	
c. LENGTH OF STAY IN lb 30 DAYS		d. STREET ADDRESS 7426 TAYLOR STREET	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM P. DE WITT		4. DATE OF DEATH Month Day Year JANUARY 27, 1961.	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH APRIL 10, 1897
9. AGE (In years last birthday) 63 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WEST VIRGINIA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WEST VIRGINIA		10b. KIND OF BUSINESS OR INDUSTRY U. S. A.	
11. BIRTHPLACE (County & State, or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME GEORGE DE WITT		14. MOTHER'S MAIDEN NAME MARGARET MACKIE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. MEMORIAL HOSPITAL - CUMBERLAND, MD.	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Perforated diverticulitis, colon 540.1 DUE TO (b) Left lower lobe pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) Gastric Resection for Penetr. ulcer PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis & nephrosclerosis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (his hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on.....19....., and that death occurred at.....12:30 PM..... from the causes and on the date stated above.			
22a. SIGNATURE Dr. A. J. Mirkin		22b. DATE SIGNED 1-28-61	
22c. PHYSICIAN'S NAME (Type) DR. A. J. MIRKIN		22d. ADDRESS 115 SOUTH CENTRE ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/30/61	
23c. NAME OF CEMETERY OR CREMATORY Philos Cem.		23d. LOCATION (City, town or county) (State) Westernport, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE C.S. Boul		25a. REC'D BY REGISTRAR FEB 2 '61	
ADDRESS Westernport, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

00029

010

PRINCE GEORGE

WYLAND

ALLEGANY

WYLAND

30 DAYS

CUMBERLAND

TAYLOR STREET

HOSPITAL

JANUARY - 27, 1911

DE WITT

WILLIAM

APRIL 10, 1911

MALE

U. S. A.

WEST VIRGINIA

MARGARET MCKENZIE

GEORGE DE WITT

1

HOSPITAL - CUMBERLAND, MD.

no

THE SOUTH CENTRAL ST., CUMBERLAND, MD.

U. S. A. MCKENZIE

HOSPITAL, CUMBERLAND, MD.

HOSPITAL, CUMBERLAND, MD.

WYLAND

WYLAND

U. S. A.

U. S. A.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00020

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>14 Days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sacred Heart Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>LLOYD</u> Middle <u>THURMAN</u> Last <u>DRAKE</u>				4. DATE OF DEATH Month <u>January</u> Day <u>3</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 26, 1915</u>	
9. AGE (In years last birthday) <u>45</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance Line</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>G.L. Martin Aircraft</u>		11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Isaac Drake</u>				14. MOTHER'S MAIDEN NAME <u>Esther Dolan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-14-6891</u>		17. INFORMANT <u>Franklin Drake, Cumberland, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EDEMA;; CARDIAC FAILURE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>COR TRUNK PULMONALE</u> DUE TO (c) <u>EMPHYSEMA, BRONCHIECTASIS</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2-3 Days</u> <u>1-2 Yrs.</u> <u>1 Yr.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u> </u> <u> </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Benedict Skitarelic</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/5/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, Cumberland, Maryland</u>				24a. REC'D BY REGISTRAR <u>JAN 6 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

10030

MARY AND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED [Blank]		2. SEX [Blank]	
3. AGE [Blank]		4. RACE [Blank]	
5. DATE OF DEATH [Blank]		6. TIME OF DEATH [Blank]	
7. PLACE OF DEATH [Blank]		8. OCCUPATION [Blank]	
9. MARITAL STATUS [Blank]		10. EDUCATION [Blank]	
11. BIRTH DATE [Blank]		12. BIRTH PLACE [Blank]	
13. PRESENT ADDRESS [Blank]		14. PREVIOUS ADDRESS [Blank]	
15. CAUSE OF DEATH [Blank]		16. MANNER OF DEATH [Blank]	
17. MEDICAL HISTORY [Blank]		18. SOCIAL HISTORY [Blank]	
19. PHYSICAL EXAMINATION [Blank]		20. LABORATORY TESTS [Blank]	
21. TREATMENT [Blank]		22. SIGNATURE OF EXAMINER [Blank]	
23. DATE OF EXAMINATION [Blank]		24. OFFICIAL USE [Blank]	

Vertical text on the right margin, likely a filing or processing stamp.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

021

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00021

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport		c. LENGTH OF STAY IN 1b 69 Yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 218 Popular		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Francis Middle Fazenbaker Last Fazenbaker		4. DATE OF DEATH Month Jan. Day 10 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 21, 1891
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months 69 Days 10 Hours 10 Min. 10	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY City of Westernport Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A./	
13. FATHER'S NAME Augustus Fazenbaker		14. MOTHER'S MAIDEN NAME Ida Dawson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 705-10-7026	
17. INFORMANT Howard Fazenbaker-Dover, Ohio.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 331X IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Hypertension DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Found Dead in Home by Neighbor			
INTERVAL BETWEEN ONSET AND DEATH 30 minutes 5 Years			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Jan 10 19 61 , that (I) (we) last saw the deceased Jan 10 19 61 , and that death occurred at 4P M, from the causes and on the date stated above.			
22a. SIGNATURE Paul R. Wilson			
22b. DATE SIGNED Jan. 12, 1961			
22c. PHYSICIAN'S NAME (Type) Paul R. Wilson, M.D.			
22d. ADDRESS Piedmont, W. Va.			
22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23b. DATE THEREOF 1/13/61			
23c. NAME OF CEMETERY OR CREMATORY Philos			
23d. LOCATION (City, town, or county) (State) Westernport Md.			
24. FUNERAL DIRECTOR'S SIGNATURE El. Boul			
ADDRESS Westernport, Md.			
25a. REC'D BY REGISTRAR JAN 16 '61			
25b. REGISTRAR'S SIGNATURE Arthur S. Kline			

1900

CERTIFICATE OF DEATH

1900

Age

Sex

Married

Occupation

Residence

Place of Birth

Time of Death

Place of Death

Signature

Signature

Date

Time

Place of Death

Signature

Signature

Signature

Signature

Signature

Signature

Signature

X

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

TO HOSPITAL FOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
022 CERTIFICATE OF DEATH 00023

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 38 DAYS	
d. NAME OF HOSPITAL (If not in hospital, write address) MEMORIAL HOSPITAL WARWICK & MEMORIAL AVENUES		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FRANCISCO Middle FRAGOMENI Last FRAGOMENI		4. DATE OF DEATH Month JANUARY Day 12 Year 1961	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 30, 1882
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (State or foreign country) ITALY Caulonia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME JOHN FRAGOMENI		14. MOTHER'S MAIDEN NAME TERESA ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-10-2566	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Unknown 4 43X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) General Cerebrovascular DUE TO (c) Hypertensive Cerebrovascular disease with PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH Days			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug 1957 to Jan 1961 , that (I) (we) last saw the deceased alive on Jan 12 1961 , and that death occurred at 12:30 PM from the causes and on the date stated above.			
22a. SIGNATURE [Signature]		22b. DATE SIGNED 1/13/61	
22c. PHYSICIAN'S NAME (Type) DR. G. OVERTON HIMMELWRIGHT		22d. ADDRESS 133 VIRGINIA AVE., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF I-14-61	
23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		23d. LOCATION (City, town, or county) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		25. REC'D BY REGISTRAR DATE JAN 17 '61	
ADDRESS Cumberland, Md.		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

00023

CERTIFICATE OF DEATH

023



ALLIANCE

WYLAND

ALLIANCE

CINERLAND

28 DAYS

CINERLAND

101 BANCOR STREET

WOMAN & CHILDREN

WYLAND

WYLAND

WYLAND

APRIL 30, 1925

WHITE

ITALY CAROLINA

DELICIOUS

DELICIOUS

TERESA

TERESA

NO. 120-11-3886 HONOLULU HOSPITAL - CINERLAND, HI.

123 VIRGINIA AVE., CINERLAND, HI.

DR. G. OVERTON HOSPITAL

1-1-21

JAMES F. HOSPITAL

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial-transit permit, or removal.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
02 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00024

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 41 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. Memorial Hospital				d. STREET ADDRESS 446 Seymour St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle E. Last Gurtler				4. DATE OF DEATH Month Jan. Day 22 Year 19 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 25, 1919	
9. AGE (In years last birthday) 41 yrs.		IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer				10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Cumberland, Md.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Ellis Gurtler				14. MOTHER'S MAIDEN NAME Jane Reed			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) yes (If yes, give war or dates of service) War II				16. SOCIAL SECURITY NO. 219-03-8250		17. INFORMANT Mrs. George Gurtler, Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE HEPATIC FAILURE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) FATTY INFILTRATION OF LIVER DUE TO (c) CHRONIC ALCOHOLISM				INTERVAL BETWEEN ONSET AND DEATH SUDDEN			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Benedict Skitaralis				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 25, 1960		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.				24a. REC'D BY REGISTRAR DATE JAN 31 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

024

CERTIFICATE OF DEATH

Reg. Dist. No.

C0025

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE W. Va. b. COUNTY Mineral	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,		c. LENGTH OF STAY IN 1b Fort Ashby 85X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kelly-Tire Co. Infirmary		d. STREET ADDRESS Along St. Rt. # 28	
3. NAME OF DECEASED (Type or print) FRANCIS McCELLAN HAMILTON		4. DATE OF DEATH Month Jan. Day 27, Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 11, 1900
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months 27 Days 27 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Welder		10b. KIND OF BUSINESS OR INDUSTRY Kelly-Tire Co.	
11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Francis M. Hamilton		14. MOTHER'S MAIDEN NAME Lula R. Little	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes. W. W. #2		16. SOCIAL SECURITY NO. 17. INFORMANT Mrs. Mary F. Hamilton Ft. Ashby, W. Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis - Vent. Fabr. 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Artery Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH Summer 4 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) Cumberland Allegany West	
21. I certify that I attended the deceased from 2/7/55 , 19____, to 1/27/61 , 19____, that I last saw the deceased alive on 1/26/61 , 19____, and that death occurred at 6:20 M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 122 So. Centre St., DATE SIGNED 1/28/61	
ACTUAL SIGNATURE Richard J. Williams M.D.		PHYSICIAN'S NAME (Type) Richard J. Williams M.D. Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/30/61	
22c. NAME OF CEMETERY OR CREMATORY Arnold Cemetery		22d. LOCATION (City, town, or county) (State) Junction, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George Cumberland, Md.		24a. REC'D BY REGISTRAR JAN 31 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Finner			

CERTIFICATE OF DEATH

NAME OF DECEASED [REDACTED]		SEX [REDACTED]		AGE [REDACTED]	
PLACE OF BIRTH [REDACTED]		OCCUPATION [REDACTED]		MARITAL STATUS [REDACTED]	
DATE OF DEATH [REDACTED]		TIME OF DEATH [REDACTED]		PLACE OF DEATH [REDACTED]	
CAUSE OF DEATH [REDACTED]		MANNER OF DEATH [REDACTED]		MEDICAL HISTORY [REDACTED]	
SIGNATURE OF PHYSICIAN [REDACTED]		SIGNATURE OF CORONER [REDACTED]		SIGNATURE OF WITNESS [REDACTED]	

This certificate is to be filled out by the physician or coroner who has examined the body of the deceased and is to be filed in the office of the State Department of Health. It is to be used for the purpose of determining the cause of death and for the purpose of recording the death. It is to be filled out in duplicate and one copy is to be retained in the office of the State Department of Health and the other copy is to be sent to the local health officer.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. For a burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
025 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00026

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>70 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Trost Avenue Extended</u>				d. STREET ADDRESS <u>Trost Avenue Extended</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Bell</u> Last <u>Hartman</u>				4. DATE OF DEATH Month <u>January</u> Day <u>6</u> Year <u>19 61</u>					
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 5, 1868</u>	9. AGE (In years last birthday) <u>92 yrs.</u>	IF UNDER 1 YEAR Months <u>6</u> Days <u>19</u> Hours <u>61</u>		IF UNDER 24 HRS. Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Burlington, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Alexander Miller</u>				14. MOTHER'S MAIDEN NAME <u>Matilda Blackburn</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Mable Riggleman</u> Address <u>Cumberland, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CHRONIC MYOCARDITIS, PULMONARY EDEMA</u> 422.1 DUE TO Circumstances, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> DUE TO (c) <u>YEARS</u>								INTERVAL BETWEEN ONSET AND DEATH <u>YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>							
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u>		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>BENEDICT SKITARELIC, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>JANUARY 7, 1960</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/8/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, Cumberland, Md.</u>				ADDRESS <u>John J. Hafer, Cumberland, Md.</u>		24a. REC'D BY REGISTRAR <u>JAN 11 1961</u>			
				DATE		24b. REGISTRAR'S SIGNATURE <u>Robert S. Kneass</u>			

0008

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>	
<p>4. OCCUPATION</p>		<p>5. PLACE OF BIRTH</p>		<p>6. DATE OF BIRTH</p>	
<p>7. PLACE OF DEATH</p>		<p>8. TIME OF DEATH</p>		<p>9. CAUSE OF DEATH</p>	
<p>10. MANNER OF DEATH</p>		<p>11. SIGNATURE OF MEDICAL EXAMINER</p>		<p>12. SIGNATURE OF CORONER</p>	
<p>13. SIGNATURE OF WITNESS</p>		<p>14. SIGNATURE OF WITNESS</p>		<p>15. SIGNATURE OF WITNESS</p>	
<p>16. SIGNATURE OF WITNESS</p>		<p>17. SIGNATURE OF WITNESS</p>		<p>18. SIGNATURE OF WITNESS</p>	
<p>19. SIGNATURE OF WITNESS</p>		<p>20. SIGNATURE OF WITNESS</p>		<p>21. SIGNATURE OF WITNESS</p>	
<p>22. SIGNATURE OF WITNESS</p>		<p>23. SIGNATURE OF WITNESS</p>		<p>24. SIGNATURE OF WITNESS</p>	
<p>25. SIGNATURE OF WITNESS</p>		<p>26. SIGNATURE OF WITNESS</p>		<p>27. SIGNATURE OF WITNESS</p>	
<p>28. SIGNATURE OF WITNESS</p>		<p>29. SIGNATURE OF WITNESS</p>		<p>30. SIGNATURE OF WITNESS</p>	
<p>31. SIGNATURE OF WITNESS</p>		<p>32. SIGNATURE OF WITNESS</p>		<p>33. SIGNATURE OF WITNESS</p>	
<p>34. SIGNATURE OF WITNESS</p>		<p>35. SIGNATURE OF WITNESS</p>		<p>36. SIGNATURE OF WITNESS</p>	
<p>37. SIGNATURE OF WITNESS</p>		<p>38. SIGNATURE OF WITNESS</p>		<p>39. SIGNATURE OF WITNESS</p>	
<p>40. SIGNATURE OF WITNESS</p>		<p>41. SIGNATURE OF WITNESS</p>		<p>42. SIGNATURE OF WITNESS</p>	
<p>43. SIGNATURE OF WITNESS</p>		<p>44. SIGNATURE OF WITNESS</p>		<p>45. SIGNATURE OF WITNESS</p>	
<p>46. SIGNATURE OF WITNESS</p>		<p>47. SIGNATURE OF WITNESS</p>		<p>48. SIGNATURE OF WITNESS</p>	
<p>49. SIGNATURE OF WITNESS</p>		<p>50. SIGNATURE OF WITNESS</p>		<p>51. SIGNATURE OF WITNESS</p>	
<p>52. SIGNATURE OF WITNESS</p>		<p>53. SIGNATURE OF WITNESS</p>		<p>54. SIGNATURE OF WITNESS</p>	
<p>55. SIGNATURE OF WITNESS</p>		<p>56. SIGNATURE OF WITNESS</p>		<p>57. SIGNATURE OF WITNESS</p>	
<p>58. SIGNATURE OF WITNESS</p>		<p>59. SIGNATURE OF WITNESS</p>		<p>60. SIGNATURE OF WITNESS</p>	
<p>61. SIGNATURE OF WITNESS</p>		<p>62. SIGNATURE OF WITNESS</p>		<p>63. SIGNATURE OF WITNESS</p>	
<p>64. SIGNATURE OF WITNESS</p>		<p>65. SIGNATURE OF WITNESS</p>		<p>66. SIGNATURE OF WITNESS</p>	
<p>67. SIGNATURE OF WITNESS</p>		<p>68. SIGNATURE OF WITNESS</p>		<p>69. SIGNATURE OF WITNESS</p>	
<p>70. SIGNATURE OF WITNESS</p>		<p>71. SIGNATURE OF WITNESS</p>		<p>72. SIGNATURE OF WITNESS</p>	
<p>73. SIGNATURE OF WITNESS</p>		<p>74. SIGNATURE OF WITNESS</p>		<p>75. SIGNATURE OF WITNESS</p>	
<p>76. SIGNATURE OF WITNESS</p>		<p>77. SIGNATURE OF WITNESS</p>		<p>78. SIGNATURE OF WITNESS</p>	
<p>79. SIGNATURE OF WITNESS</p>		<p>80. SIGNATURE OF WITNESS</p>		<p>81. SIGNATURE OF WITNESS</p>	
<p>82. SIGNATURE OF WITNESS</p>		<p>83. SIGNATURE OF WITNESS</p>		<p>84. SIGNATURE OF WITNESS</p>	
<p>85. SIGNATURE OF WITNESS</p>		<p>86. SIGNATURE OF WITNESS</p>		<p>87. SIGNATURE OF WITNESS</p>	
<p>88. SIGNATURE OF WITNESS</p>		<p>89. SIGNATURE OF WITNESS</p>		<p>90. SIGNATURE OF WITNESS</p>	
<p>91. SIGNATURE OF WITNESS</p>		<p>92. SIGNATURE OF WITNESS</p>		<p>93. SIGNATURE OF WITNESS</p>	
<p>94. SIGNATURE OF WITNESS</p>		<p>95. SIGNATURE OF WITNESS</p>		<p>96. SIGNATURE OF WITNESS</p>	
<p>97. SIGNATURE OF WITNESS</p>		<p>98. SIGNATURE OF WITNESS</p>		<p>99. SIGNATURE OF WITNESS</p>	
<p>100. SIGNATURE OF WITNESS</p>		<p>101. SIGNATURE OF WITNESS</p>		<p>102. SIGNATURE OF WITNESS</p>	

026

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00027

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 3 HOURS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARGIE Middle M. Last HARTMAN				4. DATE OF DEATH Month JANUARY Day 11 Year 1961			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH JUNE 12, 1911	
9. AGE (In years lost birthday) 49 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) PETERSBURG, W. VA.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME BLAIR MONGOLD				14. MOTHER'S MAIDEN NAME SARAH KUYKENDOLL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of colon, metastatic 7 yr 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 19 P.M. 19____, that (I) (we) last saw the deceased alive on 19 , and that death occurred at 7:21 P.M. from the causes and on the date stated above.							
22a. SIGNATURE <i>Dr. A. J. Mirkin</i>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) DR. A. J. MIRKIN				22d. ADDRESS 115 SOUTH CENTRE ST. CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/14/61		23c. NAME OF CEMETERY OR CREMATORY New House Cemetery		23d. LOCATION (City, town, or county) (State) Pigg. W. Va.	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Blaine Schaeffer</i>				25a. REC'D BY REGISTRAR DATE JAN 16 '61		25b. REGISTRAR'S SIGNATURE <i>Christina S. Kline</i>	

00023

CENTRE CASE 0-0241

020

ALLEGEDLY

INVESTIGATED

ALL BODIES

FLINTSTONE (POINT 5 2)

3 HOURS

RECEIVED

RECEIVED 10/11/11

RECEIVED 10/11/11

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JUNE 15, 1911

WHITE

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11

RECEIVED 10/11/11

DR. J. J. MURKIN

11 SOUTH CENTRE ST. LUNEBRAND, N.Y.

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
027
CERTIFICATE OF DEATH
00001

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 55 MINUTES d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND d. STREET ADDRESS RT.#3, PINE RIDGE ROAD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>																			
3. NAME OF DECEASED (Type or print) HEAVNER		4. DATE OF DEATH Month JANUARY Day 8 Year 19 61		5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JANUARY 8, 1961		9. AGE (In years last birthday) yrs. 55		IF UNDER 1 YEAR Months 55		IF UNDER 24 HRS. Hours 55		Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MARYLAND				12. CITIZEN OF WHAT COUNTRY? U.S.A.											
13. FATHER'S NAME DOUGLAS B. HEAVNER, JR.				14. MOTHER'S MAIDEN NAME SARAH B. THOMAS				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)								16. SOCIAL SECURITY NO.				17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 773.5 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) respiratory failure (c) pneumonia																INTERVAL BETWEEN ONSET AND DEATH 70 minutes							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)																19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)																			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on.....19....., and that death occurred on Jan 10 AM from the causes and on the date stated above.																							
22a. SIGNATURE Lewis Brings				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED															
22c. PHYSICIAN'S NAME (Type) LEWIS BRINGS				22d. ADDRESS 57 GREENE ST., CUMBERLAND, MD.																			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation				23b. DATE THEREOF 1-9-61				23c. NAME OF CEMETERY OR CREMATORY Memorial Hospital				23d. LOCATION (City, town or county) Cumberland, Maryland				(State)							
24. FUNERAL DIRECTOR'S SIGNATURE Memorial Hospital, Cumberland, Md				ADDRESS				25a. REC'D BY REGISTRAR DATE JAN 10 '61				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus											

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ALLEGANY

WHEELING

ALLEGANY

CHESLAND

ST. LOUIS

CHESLAND

ST. LOUIS, MISSOURI

ST. LOUIS, MISSOURI

ALLEGANY

WHEELING

ALLEGANY

WHITE

MALE

U.S.A.

CHESLAND, ALLEGANY

ALLEGANY

DOUGLAS B. HEAVES, JR.

CHESLAND, ALLEGANY

ST. LOUIS, MISSOURI

ST. LOUIS, MISSOURI

ALLEGANY

WHEELING

may be required by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

028

00028

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 510 Cumberland St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ETHEL Middle LEIGH Last HELLER				4. DATE OF DEATH Month Jan. Day 4 Year 19 61			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 6, 1895	9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Cumberland, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles W. Hammond				14. MOTHER'S MAIDEN NAME Nellie Gubbage			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Charles Heller, Cumberland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Artery Disease DUE TO (c) —						INTERVAL BETWEEN ONSET AND DEATH 1 hr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Cumberland, Md.	(County) Allegany	(State) Md.		
21. I certify that (I) (this hospital) attended the deceased from 1/12/52 19 to 1/4/61 19, that (I) (we) last saw the deceased alive on 1/4/61 19, and that death occurred at 6 P. M, from the causes and on the date stated above.							
22a. SIGNATURE [Signature]		22b. PHYSICIAN'S NAME (Type) [Signature]		22c. ADDRESS Cumberland, Md.		22d. DATE SIGNED 1/6/61	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/8/1961	23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Cumberland, Md.		
24. FUNERAL DIRECTOR'S SIGNATURE Byron Knight				25a. REC'D BY REGISTRAR DATE JAN 9 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

1928

1928

FILE NO.
100-100000

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the document]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
029
CERTIFICATE OF DEATH

00029

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 7 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First RHODA Middle ANNA Last HELMSTETTER				4. DATE OF DEATH Month JAN Day 5 Year 19 61			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/5/98	
9. AGE (In years last birthday) 62 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ambrose Morris				14. MOTHER'S MAIDEN NAME Sarah Neus			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-32-4648		17. INFORMANT CHART			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute cor pulmonale 501X DUE TO asthma bronchitis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) pneumonia, uremia, diabetes mellitus				INTERVAL BETWEEN ONSET AND DEATH 6 days years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from August 1961 to 1/5 19 61 , that (I) (we) last saw the deceased alive on 1/4 19 61 , and that death occurred at AM , from the causes and on the date stated above.							
22a. SIGNATURE Elizabeth Brings				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) DR. ELIZABETH BRINGS				22d. ADDRESS 55 EMMET GREENE STREET			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/9/61		23c. NAME OF CEMETERY OR CREMATORY Sts. Peter and Paul's Cem.		23d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Md.				25a. REC'D BY REGISTRAR DATE JAN 9 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

UNITED STATES DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
DIVISION OF VITAL RECORDS
OFFICE OF THE REGISTRAR
WASHINGTON, D. C. 20540
CERTIFICATE OF DEATH

028

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1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]	
3. AGE [Faint text]		4. DATE OF BIRTH [Faint text]	
5. PLACE OF BIRTH [Faint text]		6. PLACE OF DEATH [Faint text]	
7. OCCUPATION [Faint text]		8. CAUSE OF DEATH [Faint text]	
9. MANNER OF DEATH [Faint text]		10. SIGNATURE OF REGISTRAR [Faint text]	
11. SIGNATURE OF DECEASED [Faint text]		12. SIGNATURE OF WITNESSES [Faint text]	
13. SIGNATURE OF FUNERAL HOME [Faint text]		14. SIGNATURE OF PHYSICIAN [Faint text]	
15. SIGNATURE OF CHURCH [Faint text]		16. SIGNATURE OF OTHER [Faint text]	



MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

030

00030

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 16 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL FLINTSTONE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL				d. STREET ADDRESS 1			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First HOWARD Middle DEWITT Last HENDRICKSON				4. DATE OF DEATH Month JAN. Day 23 Year 19 61			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 30, 1900		9. AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER			10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME HOWARD H. HENDRICKSON				14. MOTHER'S MAIDEN NAME NANCY WENTLING			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT PATIENT'S CHART Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of the sigmoid 153.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 1 year
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4-1-1960 to 1-23-1961 , that (I) (we) lost saw the deceased alive on 1-23-1961 , and that death occurred at 4:58 P.M. from the causes and on the date stated above.							
22a. SIGNATURE L. Brings				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) LEWIS BRINGS, M.D.				22d. ADDRESS 57 GREENE ST., CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/26/61		23c. NAME OF CEMETERY OR CREMATORY I.O.O.F. Cemetery		23d. LOCATION (City, town, or county) (State) Flintstone, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Md. ADDRESS				25a. REC'D BY REGISTRAR DATE JAN 30 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Hana	

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UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.
OFFICE OF THE ASSISTANT SECRETARY
OF PLANT INDUSTRY
OFFICE OF THE ASSISTANT SECRETARY
OF PLANT INDUSTRY
OFFICE OF THE ASSISTANT SECRETARY
OF PLANT INDUSTRY

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DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00031

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 60 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) MEMORIAL HOSPITAL				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND d. STREET ADDRESS 219 ARCH STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last ESTEL L. HETRICK				4. DATE OF DEATH Month Day Year JANUARY 9 1961			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 29, 1909	
9. AGE (In years lost birthday) yrs. 51		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Driver		10b. KIND OF BUSINESS OR INDUSTRY Taxi Cab Co.	
11. BIRTHPLACE (State or foreign country) MARYLAND-CUMBERLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME LLOYD HETRICK		14. MOTHER'S MAIDEN NAME OPAL NIXON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 217-14-4007		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Atherosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Myocardial Degeneration						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/10 to 11/9 , 19 60 , that (I) (we) last saw the deceased alive on 1/9 19 61 , and that death occurred at 11:50 PM , from the causes and on the date stated above.							
22a. SIGNATURE Leo H. Ley				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) DR. LEO H. LEY				22d. ADDRESS 456 N. CENTRE ST., CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-12-1961		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.				25a. REC'D BY REGISTRAR 13 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Howard	

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TAP-01-018

100 : 13

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MAYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
032
CERTIFICATE OF DEATH
C0032

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 41 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND d. STREET ADDRESS 125 NEW HAMPSHIRE AVENUE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last JOHN F. KELLER		4. DATE OF DEATH Month Day Year JANUARY 6 19 61	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 19, 1903
9. AGE (In years last birthday) 57 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINIST	11. BIRTHPLACE (County & State, or foreign country) GERMANY
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME KELLER, F. Keller	
14. MOTHER'S MAIDEN NAME BARBARA SAUNDERS		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No	
16. SOCIAL SECURITY NO. 217-10-7410		17. INFORMANT Address MEMORIAL HOSPITAL CUMBERLAND, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 204.2 DUE TO Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last. } DUE TO (c) Cause Myocardial Infarction INTERVAL BETWEEN ONSET AND DEATH 15 hours		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan 5, 1961 5:59 AM. to Jan 6, 1961 2:35 AM. that (I) (we) last saw the deceased alive on Jan 6, 1961 and that death occurred at 2:35 AM. from the causes and on the date stated above.			
22a. SIGNATURE Dr. O. G. Himmelwright		22b. DATE SIGNED 1/11/61	
22c. PHYSICIAN'S NAME (Type) DR. O. G. HIMMELWRIGHT		22d. ADDRESS 1331/2 Ave Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF I-9-61	23c. NAME OF CEMETERY OR CREMATORY Rest Lawn Memorial Park	23d. LOCATION (City, town or county) (State) Cumberland, Md.
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		25a. REC'D BY REGISTRAR JAN 11 '61	
25b. REGISTRAR'S SIGNATURE Charles S. Kline			

(M)

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00033

GENERAL HOSPITAL

125 NEW YORK AVENUE

JOHN

KELLY

WILLIAM

WHITE

JUNE 12, 1903

ST

1001 1ST

(EXCLUSIVE AND)

NEW YORK

U.S.A.

BARRERA CHURCH

KELLY, T. KELLY

217-10-1010 GENERAL HOSPITAL - NEW YORK, NEW YORK

NO

IN 24 HOURS

[Handwritten signature]

DR. O. H. HILTON

East Lawn Memorial Park Cemetery, N.Y.

1-2-21

Burial

James F. Scott, 111 Chambers St., N.Y.

111 Chambers St., N.Y.

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

033

00002

1. PLACE OF DEATH a. COUNTY Allegany		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Barton		c. LENGTH OF STAY IN TB 85 Yrs		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md.		b. COUNTY Allegany		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Barton		d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Richard		Middle D.		Last Keyes		4. DATE OF DEATH Month Jan.		Day 20		Year 1961					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 12, 1875		9. AGE (in years last birthday) 85 yrs.		IF UNDER 1 YEAR Months Days 		IF UNDER 24 HRS. Hours Min. 					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plasterer				10b. KIND OF BUSINESS OR INDUSTRY Concruction				11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Phillip Keyes						14. MOTHER'S MAIDEN NAME Elizabeth Warnick											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no				16. SOCIAL SECURITY NO. 		17. INFORMANT Mary Keyes Barton, Md.				Address 							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Thrombosis DUE TO (b) Coronary Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO (c) 												INTERVAL BETWEEN ONSET AND DEATH Sudden ?					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)																	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)													
22c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Barton		(County) Allegany		(State) Md.					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Frostburg, Md.																	
ACTUAL SIGNATURE W.O. McLane				M.D. W.O. McLane				DATE SIGNED 1-21-61									
EXAMINER'S NAME (Type) W.O. McLane				Address (Street, city, town, or county) Frostburg, Md.													
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 123/61		22c. NAME OF CEMETERY OR CREMATORY Laurel Hill				22d. LOCATION (City, town, or country) Moscow, Md.				(State) Md.			
23. FUNERAL DIRECTOR El. Boal				ADDRESS Westernport, Md.				24a. REC'D BY REGISTRAR JAN 23 '61				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus					

MEDICAL CERTIFICATION

FOR STATE
MAINTENANCE

038

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Richard
Philip
Maryland
U.S.A.
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **00033**

034

Item 8 Film 6279 1-16-61 et

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN lb 65 years			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Homewood Addition				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARY Middle E. Last KNIERIEM				4. DATE OF DEATH Month Jan. Day 7 Year 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 27, 1873 1874	
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months 7 Days 7		IF UNDER 24 HRS. Hours 7 Min. 7			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Penna.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Michael H. Diehl				14. MOTHER'S MAIDEN NAME Mary Howser			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Eldon Paxton, Homewood Add. Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION V DUE TO CORONARY SCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CORONARY SCLEROSIS DUE TO (c) CORONARY SCLEROSIS INTERVAL BETWEEN ONSET AND DEATH SUDDEN							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Benedict Skitarelic M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Benedict Skitarelic M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 10, 1961		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Byron Kight				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE JAN 10 '61	
						24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar for a burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00034

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF DEATH	
5. PLACE OF DEATH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR	
9. STREET ADDRESS		10. CITY		11. STATE		12. ZIP CODE	
13. MANNER OF DEATH		14. CAUSE OF DEATH		15. MECHANISM OF DEATH		16. TOXICOLOGICAL EXAMINATION	
17. SIGNATURE OF EXAMINER		18. SIGNATURE OF WITNESS		19. SIGNATURE OF CORONER		20. SIGNATURE OF JURY	
21. SIGNATURE OF DECEASED		22. SIGNATURE OF NEXT OF KIN		23. SIGNATURE OF PRIEST		24. SIGNATURE OF MINISTER	
25. SIGNATURE OF CHURCH		26. SIGNATURE OF FUNERAL HOME		27. SIGNATURE OF BURIAL		28. SIGNATURE OF CREMATION	
29. SIGNATURE OF INTERMENT		30. SIGNATURE OF REINTERMENT		31. SIGNATURE OF REINTERMENT		32. SIGNATURE OF REINTERMENT	
33. SIGNATURE OF REINTERMENT		34. SIGNATURE OF REINTERMENT		35. SIGNATURE OF REINTERMENT		36. SIGNATURE OF REINTERMENT	
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97. SIGNATURE OF REINTERMENT		98. SIGNATURE OF REINTERMENT		99. SIGNATURE OF REINTERMENT		100. SIGNATURE OF REINTERMENT	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
035
CERTIFICATE OF DEATH

C0034

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 27 Grand Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Clarence Sidney Lewis				4. DATE OF DEATH Month Jan. Day 22 Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 23, 1870	
9. AGE (In years last birthday) 90 yrs.		IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Master Mech. Railroad				10b. KIND OF BUSINESS OR INDUSTRY Middletown, Va.			
11. BIRTHPLACE (County & State, or foreign country) Middletown, Va.				12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Gordon Lewis				14. MOTHER'S MAIDEN NAME Sara C. Rhodes			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give year or dates of service)				16. SOCIAL SECURITY NO. Miss Mabel H. Lewis, Cumberland, Md.			
17. INFORMANT Miss Mabel H. Lewis, Cumberland, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Strain Conditions, if any, which gave rise to immediate cause (b) Myocarditis (c) Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 7 yrs. 10 yrs.				INTERVAL BETWEEN ONSET AND DEATH 6 wks.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from January 1958 to January 1961 , that (I) (we) last saw the deceased alive on Jan. 18, 1961 , and that death occurred at 11:00 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Clay E. Durrett M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. Clay E. Durrett, M.D.				22d. ADDRESS 236 Va. Ave. Cumberland, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 26, 1961		23c. NAME OF CEMETERY OR CREMATORY Green Hill Cemetery		23d. LOCATION (City, town or county) (State) Stephen City, Va.	
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.				ADDRESS James F. Scarpelli, Cumberland, Md.		25a. REC'D BY REGISTRAR DATE JAN 27 '61	
				25b. REGISTRAR'S SIGNATURE Arthur S. Evans			

00038

055

Albany

Albany

Albany

Cambridge

60 yrs.

Cambridge

27 Grand Ave.

27 Grand Ave.

61

Jan.

Lewis

Albany

Cambridge

March 23, 1870

x

White

White

Richmond, Va.

Richmond

Richmond, Va.

John C. Rhodes

Gordon Lewis

1

Miss Isabel H. Lewis, Cambridge, Va.

no

Dr. Charles F. Barrett, N.D.

Stephen City, Va.

John C. Rhodes, 1801

Barrett

James F. Scott, Cambridge, Va.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1
036
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
00035

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 31 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First THELMA Middle Last LEWIS				4. DATE OF DEATH Month JANUARY Day 10 Year 1961			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH DEC. 22, 1906	
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Twisting Dept.				10b. KIND OF BUSINESS OR INDUSTRY Textile		11. BIRTHPLACE (State or foreign country) CUMBERLAND, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME CHARLES W. JACKSON				14. MOTHER'S MAIDEN NAME FLORENCE VALENTINE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 217-10-7022		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO 332 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Artery disease advanced DUE TO Cerebral Arteriosclerosis (c) Cerebral Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None INTERVAL BETWEEN ONSET AND DEATH 12-10-60							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 12-10-60 to 1-10-61 that (I) (we) last saw the deceased alive on 1-10-61 and that death occurred 6:20 PM from the causes and on the date stated above.							
22a. SIGNATURE W.F. Williams M.D.				22b. DATE SIGNED 1-10-61			
22c. PHYSICIAN'S NAME (Type) W.F. WILLIAMS				22d. ADDRESS 122 SOUTH CENTRE ST., CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-13-1961		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		23d. LOCATION (City, town, or county) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.				25a. REC'D BY REGISTRAR JAN 13 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Hume	

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ALZAM

2530-15

MEMORIAL & MONUMENTAL ASSOCIATION

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[illegible]

2017-3-14 PM 3:03

ON QUALIFIED TRUSTS: WOOD SS

[illegible]

may be required by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

037 CERTIFICATE OF DEATH

C0036

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RFD 2, Frostburg				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RFD 2, Frostburg			
c. LENGTH OF STAY IN 1b 45 yrs.				d. STREET ADDRESS Hope Road			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hope Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Elizabeth Middle Jane Last Lohr				4. DATE OF DEATH Month January Day 17th Year 1961			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 22nd, 1887		9. AGE (In years lost birthday) 73 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own housework		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Geary				14. MOTHER'S MAIDEN NAME Eliza Jane Poole			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT J. Edison Lohr, RFD 2, Hope Road, F'bg. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute Cardiac Dilatation 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) myocardial Insufficiency DUE TO (c) Sudden Sereal Months						INTERVAL BETWEEN ONSET AND DEATH Sudden Sereal Months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 1, 1960 to Jan 2, 1961 , that (I) (we) last saw the deceased alive on Jan 14, 1961 , and that death occurred at 11 PM , from the causes and on the date stated above.							
22a. SIGNATURE W. O. McLane				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Jan 18/61	
22c. PHYSICIAN'S NAME (Type) W. O. McLane,				22d. ADDRESS 167 E. Main St., Frostburg, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-20-61		23c. NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park		23d. LOCATION (City, town, or county) (State) Frostburg, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst				ADDRESS Frostburg, Md.		25a. REC'D BY REGISTRAR DATE JAN 23 '61	
				25b. REGISTRAR'S SIGNATURE Arthur S. Thoms			

MEDICAL CERTIFICATION

60030

OFFICE OF THE ATTORNEY GENERAL

037

Attorney

Attorney

Attorney

W.D. S. Thompson

11 yrs.

W.D. S. Thompson

John S. Smith

January 1, 1900

January 1, 1900

at 22, 1887

at 22, 1887

037

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Ellis Lane 1810

Ellis Lane 1810

at 22, 1887

*Great Lakes & Atlantic
Commercial Insurance*

Insured

Oct 1 1887

Jan 1 1888

at 22, 1887

at 22, 1887

at 22, 1887

at 22, 1887

at 22, 1887

at 22, 1887

at 22, 1887

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

038

C0037

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>				d. STREET ADDRESS <u>711 N. Mechanic St.,</u>			
3. NAME OF DECEASED (Type or print) First <u>Guy</u> Middle <u>Foghtman</u> Last <u>Long</u>				4. DATE OF DEATH Month <u>January</u> Day <u>1st</u> Year <u>1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 9, 1905</u>		9. AGE (In years last birthday) <u>55</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Weight Master City of Cumberland</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cumberland, Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Richard W. Long</u>				14. MOTHER'S MAIDEN NAME <u>Sarah E. Darr</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. <u>217-18-4994</u>		17. INFORMANT Address <u>Cumberland, Md.</u> <u>Mrs. Mabel G. Long 711 N. Mechanic St.,</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 Congestive Heart Failure</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Renal Failure due Nephrosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>7 yrs</u> <u>7 yrs</u> <u>6 mos</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hepatic Cirrhosis & Failure smos; Diabetes mellitus</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1953</u> to <u>1/1</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>12/24</u> 19 <u>60</u> , and that death occurred at <u>8:00</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Dr. S. Weisman</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1/2/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. S. Weisman</u>				22d. ADDRESS <u>CUMBERLAND, MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/4/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Sunset Memorial Park</u>		23d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>H. Wayne George</u>				ADDRESS <u>Cumberland, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 5 '61</u>	
				25b. REGISTRAR'S SIGNATURE <u>Christ S. Hume</u>			

BP

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
039 CERTIFICATE OF DEATH C0038

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS 428 FAYETTE STREET			
3. NAME OF DECEASED (Type or print) First RENEITH Middle C. Last LOTTIG				4. DATE OF DEATH Month JANUARY Day 13 Year 19 61			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-12-1906	
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) CUMBERLAND, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME JAMES W. REYNOLDS				14. MOTHER'S MAIDEN NAME ANNA C. CONDON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. —		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Edema 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cirrhosis Liver DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c). Abdominal Distention				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 19 A.M. , 19 — , that (I) (we) last saw the deceased alive on 19 , and that death occurred on 6:30 A.M. , from the causes and on the date stated above.							
22a. SIGNATURE Dr. F. B. Whitworth				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 16 Jan 61	
22c. PHYSICIAN'S NAME (Type) DR. F. B. WHITWORTH				22d. ADDRESS 123 Bedford St Cumberland Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/16/61		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Pl		23d. LOCATION (City, town, or county) (State) Cumberland Md	
24. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc				ADDRESS Cumb. Md		25a. REC'D BY REGISTRAR DATE JAN 17 '61	
				25b. REGISTRAR'S SIGNATURE Arthur S. House			

CERTIFICATE OF DEATH

1938

ALLEGANY

INDEPENDENT

ALLEGANY

CUMBERLAND

12 DAYS

CUMBERLAND

MEMORIAL HOSPITAL

558 FAYETTE STREET

RENEATH

LEWIS

JANUARY 13

FEMALE WHITE

18-12-1908

HOOVER

CUMBERLAND, MARYLAND

JAMES V. HENOLDS

ARMY OF CONSUM

MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND

DR. F. B. WILKINSON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
040 CERTIFICATE OF DEATH

C0039

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 9/12/1959	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Rosa Middle Mae Last Mackay		4. DATE OF DEATH Month January Day 4 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/8/1868
9. AGE (In years last birthday) 92 yrs.		10. IF UNDER 1 YEAR Months 4 Days 19	11. IF UNDER 24 HRS. Hours 61 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Winchester, Virginia	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Thomas Allen		14. MOTHER'S MAIDEN NAME Mary Howard	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. P.O. Box 599	
17. INFORMANT Allegany County Infirmary records		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocardial Degeneration DUE TO 592X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral arteriosclerosis DUE TO (c) Chronic Nephritis		INTERVAL BETWEEN ONSET AND DEATH ? ? ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile Deterioration		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/12/59 19____ to 1/4/61 19____, that (I) (we) last saw the deceased alive on 1/4/61 19____ @ 3:15 P.M. , and that death occurred at ____ M., from the causes and on the date stated above.			
22a. SIGNATURE James E. McLean		22b. DATE SIGNED 1/4/61	
22c. PHYSICIAN'S NAME (Type) Dr. James E. McLean		22d. ADDRESS 49 Greene St., Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/7/1960	
23c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		23d. LOCATION (City, town, or county) (State) Lonaconing, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHHORN		ADDRESS LONACONING, MD.	
25a. REC'D BY REGISTRAR JAN 9 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Knepp	

00039

CENTINATE OF DEATH

050

Allegany

Allegany

Allegany

non-acting

9/18/1979

Allegany

Grand Jurors

Allegany County, West Virginia

Rose

and

Money

and

82

7/1/80

12

Allegany County, West Virginia

Honorable

Honorable, Virginia

Thomas Allen

James Brown

Allegany County, West Virginia

Allegany County, West Virginia

Allegany County, West Virginia

Allegany County, West Virginia

10/1/81

9/18/79

1/1/81

10/1/81

Allegany County, West Virginia

Allegany County, West Virginia

Allegany County, West Virginia

Allegany County, West Virginia

Allegany County, West Virginia

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
041 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00040

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MT. SAVAGE				c. LENGTH OF STAY IN lb LIFE			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS MT. SAVAGE			
3. NAME OF DECEASED (Type or print) First Middle Last JOHN ANDREW MALLOY				4. DATE OF DEATH Month Day Year JANUARY 7, 19 61			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAY 7, 1897	
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER				10b. KIND OF BUSINESS OR INDUSTRY MT. SAVAGE REFRACTORIES		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME JOHN T. MALLOY				14. MOTHER'S MAIDEN NAME MARY HATTIE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) YES WW 1				16. SOCIAL SECURITY NO. 214-01-0069			
17. INFORMANT MRS. NINA MALLOY, MT. SAVAGE, MD.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis DUE TO (b) Coronary sclerosis Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Fastburg, Md DATE SIGNED 1-7-61							
ACTUAL SIGNATURE WOMcLane		EXAMINER'S NAME (Type) WOMcLANE MD asst					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1-10-61		22c. NAME OF CEMETERY OR CREMATORY Mt. Savage cemetery		22d. LOCATION (City, town, or country) (State) Mt Savage, Md	
23. FUNERAL DIRECTOR Joseph R. Ruxst. Frostburg Md				24b. REC'D BY REGISTRAR JAN 11 '61			
24c. REGISTRAR'S SIGNATURE Clairmont S. Hanna							

MEDICAL CERTIFICATION

020020

020020 MEDICAL EXAMINATION REPORT

100-100000-100000

NAME: JOHN E. WATSON
AGE: 35
SEX: MALE
RACE: WHITE
DATE OF BIRTH: JANUARY 1, 1907
PLACE OF BIRTH: NEW YORK, N.Y.
RESIDENT ADDRESS: 1234 5th Ave., New York, N.Y.
OCCUPATION: Salesman
EDUCATION: High School Graduate
MARRIAGE: Single
RELIGION: Catholic
MILITARY SERVICE: None
PAST MEDICAL HISTORY: None
PRESENT ILLNESS: None
PHYSICAL EXAMINATION: Normal
LABORATORY EXAMINATIONS: None
X

1

REMARKS: No abnormal findings.
X

SIGNED: J. E. Watson, M.D.
DATE: Jan 1, 1907
X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8,9 Film G280 2-9-61 et

042

CERTIFICATE OF DEATH

00041

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 1 mo., 3 das.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sylvan Retreat		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Katie Middle Bradley Last Marshall		4. DATE OF DEATH Month January Day 31 Year 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 22, 1882
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Bradley		14. MOTHER'S MAIDEN NAME Rebecca Miller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Bradley Marshall, Lonaconing, MD		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: (a) IMMEDIATE CAUSE (o) 331 cerebral hemorrhage 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 450 General arteriosclerosis DUE TO (c) 422 Myocardial Degeneration PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from Dec 28 H, 1960 , to Jan 31 st, 1961 , that I last saw the deceased alive on Jan 30 H, 1961 , and that death occurred at 1:00 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 49 Greene St. DATE SIGNED ACTUAL SIGNATURE James E. McLean M.D. 49 Greene St. PHYSICIAN'S NAME (Type) James E. McLean, M.D. 49 Greene St., Cumberland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/2/1961	
22c. NAME OF CEMETERY OR CREMATORY Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHORN ADDRESS LONACONING, MD.		24a. REC'D BY REGISTRAR DATE FEB 3 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

3

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

C0042

043

1. PLACE OF DEATH a. COUNTY <u>ALLEGANY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>ALLEGANY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MT. SAVAGE</u>				c. LENGTH OF STAY IN 1b <u>LIFE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CHURCH HILL</u>				d. STREET ADDRESS <u>1 Church Hill</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY PAULINE McDERMOTT</u>				4. DATE OF DEATH Month Day Year <u>JAN 3 1961</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MARCH 22, 1901</u>	
9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>WILLIAM M. FARRELL</u>				14. MOTHER'S MAIDEN NAME <u>ANNA PORTER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>R. DeSALES McDERMOTT - MT SAVAGE</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>12/5</u> , 19 <u>60</u> , to <u>1/3</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>1/2</u> , 19 <u>61</u> , and that death occurred at <u>3:00 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Leo H. Ley Jr.</u>				ADDRESS (Street, city or town, state) <u>436 N. CENTRE ST.</u> DATE SIGNED <u>1/4/61</u>			
PHYSICIAN'S NAME (Type) <u>LEO H. LEY JR. M.D.</u>				<u>Cumberland, Md</u>			
22a. BURIAL, CREMATION, REMOVA (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/5/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>SS. Peter & Paul</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Rouis Stein Inc</u> ADDRESS <u>117 Falden St</u>				24a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	
DATE <u>JAN 9 '61</u>							

CERTIFICATE OF DEATH

623

60042

NAME OF DECEASED [Faint text, possibly "JOHN DOE"]		SEX [Faint text, possibly "Male"]		AGE [Faint text, possibly "45"]		DATE OF BIRTH [Faint text, possibly "10/15/1910"]		PLACE OF BIRTH [Faint text, possibly "Baltimore, Md."]	
OCCUPATION [Faint text, possibly "Teacher"]		MARITAL STATUS [Faint text, possibly "Married"]		CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		MANNER OF DEATH [Faint text, possibly "Natural"]		PLACE OF DEATH [Faint text, possibly "Home"]	
DATE OF DEATH [Faint text, possibly "10/20/1955"]		TIME OF DEATH [Faint text, possibly "10:00 AM"]		SIGNATURE OF PHYSICIAN [Faint signature]		SIGNATURE OF REGISTRAR [Faint signature]		SIGNATURE OF WITNESS [Faint signature]	
COUNTY [Faint text, possibly "Baltimore"]		CITY [Faint text, possibly "Baltimore"]		STATE [Faint text, possibly "Md."]		ZIP CODE [Faint text, possibly "21201"]		DISTRICT [Faint text, possibly "1"]	

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, AND IN THE OFFICE OF THE HEALTH COMMISSIONER, BALTIMORE, MARYLAND. IT IS TO BE RETURNED TO THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, WITHIN TEN DAYS OF THE DATE OF DEATH.

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Payment may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

044

CERTIFICATE OF DEATH

Item 9 Film G279 1-13-61 et

C0043

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL				d. STREET ADDRESS 32 LAING AVENUE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) CARRIE M. MC DONALD				4. DATE OF DEATH JANUARY 8 19 61			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCT. 20, 1898	
9. AGE (In years last birthday) 62 1/2 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) MARYLAND - PICARDY	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME JOHN MILLER				14. MOTHER'S MAIDEN NAME ANNA LAYTON			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or date of service) no				16. SOCIAL SECURITY NO.			
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure 433.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriosclerosis causing the underlying cause listed. (c) Chronic Myocarditis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 6 months 3 years							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug 7, 1957 to Jan 7, 1961 , that (I) (we) last saw the deceased alive on Jan 7, 1961 , and that death occurred at 5:45 P.M. from the causes and on the date stated above.							
22a. SIGNATURE [Signature]				22b. DATE SIGNED 1/9/61		22c. PHYSICIAN'S NAME (Type) DR. O.G. HIMMELWRIGHT	
22d. ADDRESS 1331 A Ave Cumberland, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 11, 1961		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial		23d. LOCATION (City, town or county) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.				25a. REC'D BY REGISTRAR JAN 11 '61		25b. REGISTRAR'S SIGNATURE [Signature]	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be read by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
045
CERTIFICATE OF DEATH
Item 8 Film G281 2-20-60
1-12-61 et

C0044

1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland c. LENGTH OF STAY IN lb 3 weeks d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 20 Wempe Drive		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia b. COUNTY Harrison c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clarksburg d. STREET ADDRESS 400 Broadus Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Laura Middle B. Last Mc Guire		4. DATE OF DEATH Month Jan. Day 4 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 9, 1896
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Newberne, W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Ervin		14. MOTHER'S MAIDEN NAME Alice Westfall	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Andrew Saliga, Cumberland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/1 19 61 , to 1/4 19 61 , that (I) (we) last saw the deceased alive on 1/4 19 61 , and that death occurred at 5 P M, from the causes and on the date stated above.			
22a. SIGNATURE Leo H. Ley Jr.		22b. DATE SIGNED 1/5/61	
22c. PHYSICIAN'S NAME (Type) LEO H. LEY JR. M.D.		22d. ADDRESS 420 N. Centre St. Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF I-9-61	
23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery		23d. LOCATION (City, town, or county) (State) Clarksburg, W. Va.	
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		25a. REC'D BY REGISTRAR DATE JAN 9 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. King			

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00045

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 1/6/1961	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Margaret Middle Askey Last McMurdo		4. DATE OF DEATH Month January Day 8 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/2/1881
9. AGE (In years lost birthday) yrs. 79		10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Vale Summit, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James Askey		14. MOTHER'S MAIDEN NAME Janet Cowan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 215-20-5556	
17. INFORMANT P.O.Box 599 Allegany County Infirmary Records		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Hypertension 422.2 DUE TO Chronic Myocardial Degeneration Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Cerebral Arteriosclerosis (c) Chronic Arthritis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Arthritis INTERVAL BETWEEN ONSET AND DEATH 36 hrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/6/61 to 1/8/61 19___, that (I) (we) last saw the deceased alive on 1/7/61 19___, and that death occurred at ___ M, from the causes and on the date stated above.			
22a. SIGNATURE James E. McLean		22b. DATE SIGNED 1/9/61	
22c. PHYSICIAN'S NAME (Type) Dr. James E. McLean		22d. ADDRESS 49 Greene St., Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/11/61	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Md.		25a. REC'D BY REGISTRAR JAN 11 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

60042

CENTRAL OF DEATH

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(M)

James A. Olson
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

047

CERTIFICATE OF DEATH

C0047

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland, c. LENGTH OF STAY IN 1b 90 yrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 730 Greene St.,		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland, d. STREET ADDRESS 730 Greene St., e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First KATHERINE Middle MARIE Last MEYERS		4. DATE OF DEATH Month Jan. Day 22, Year 19 61			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 18, 1870	9. AGE (In years last birthday) 90 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Cumberland, Md.	
13. FATHER'S NAME Anthony A. Minke		14. MOTHER'S MAIDEN NAME Elizabeth Wegman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No,		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Francis A. Meyers Address Cumb. Md. 730 Greene St.,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus					INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 1/21 , 19 61 , to 1/22 , 19 61 , that I last saw the deceased alive on 1/21 , 19 61 , and that death occurred at 6:40 PM , from the causes and on the date stated above.					
ACTUAL SIGNATURE Leo H. Ley Jr.		M.D. Leo H. Ley Jr. M.D.		ADDRESS (Street, city or town, state) 456 N. Centre St., Cumberland, Md.	
DATE SIGNED 1/23/61					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/25/61		22c. NAME OF CEMETERY OR CREMATORY SS. Peter & Paul's	
22d. LOCATION (City, town, or county) Cumberland, Maryland					
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George		ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR JAN 26 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus					

60016

STATE OF NEW YORK DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

CERTIFICATE OF DEATH

FILE NO. 100-10000

<p>1. NAME OF DECEASED JOHN DOE</p>		<p>2. SEX Male</p>		<p>3. AGE 45</p>		<p>4. RACE White</p>	
<p>5. DATE OF DEATH 1950-10-15</p>		<p>6. TIME OF DEATH 10:00 AM</p>		<p>7. PLACE OF DEATH Home</p>		<p>8. CAUSE OF DEATH Heart Disease</p>	
<p>9. DISEASE OR INJURY Myocardial Infarction</p>		<p>10. MANNER OF DEATH Natural</p>		<p>11. SIGNATURE OF PHYSICIAN J. Smith</p>		<p>12. SIGNATURE OF REGISTRAR A. Jones</p>	
<p>13. SIGNATURE OF DECEASED (None)</p>		<p>14. SIGNATURE OF NEXT OF KIN J. Doe</p>		<p>15. SIGNATURE OF WITNESS J. Doe</p>		<p>16. SIGNATURE OF DECEASED (None)</p>	
<p>17. SIGNATURE OF DECEASED (None)</p>		<p>18. SIGNATURE OF DECEASED (None)</p>		<p>19. SIGNATURE OF DECEASED (None)</p>		<p>20. SIGNATURE OF DECEASED (None)</p>	
<p>21. SIGNATURE OF DECEASED (None)</p>		<p>22. SIGNATURE OF DECEASED (None)</p>		<p>23. SIGNATURE OF DECEASED (None)</p>		<p>24. SIGNATURE OF DECEASED (None)</p>	
<p>25. SIGNATURE OF DECEASED (None)</p>		<p>26. SIGNATURE OF DECEASED (None)</p>		<p>27. SIGNATURE OF DECEASED (None)</p>		<p>28. SIGNATURE OF DECEASED (None)</p>	
<p>29. SIGNATURE OF DECEASED (None)</p>		<p>30. SIGNATURE OF DECEASED (None)</p>		<p>31. SIGNATURE OF DECEASED (None)</p>		<p>32. SIGNATURE OF DECEASED (None)</p>	
<p>33. SIGNATURE OF DECEASED (None)</p>		<p>34. SIGNATURE OF DECEASED (None)</p>		<p>35. SIGNATURE OF DECEASED (None)</p>		<p>36. SIGNATURE OF DECEASED (None)</p>	
<p>37. SIGNATURE OF DECEASED (None)</p>		<p>38. SIGNATURE OF DECEASED (None)</p>		<p>39. SIGNATURE OF DECEASED (None)</p>		<p>40. SIGNATURE OF DECEASED (None)</p>	
<p>41. SIGNATURE OF DECEASED (None)</p>		<p>42. SIGNATURE OF DECEASED (None)</p>		<p>43. SIGNATURE OF DECEASED (None)</p>		<p>44. SIGNATURE OF DECEASED (None)</p>	
<p>45. SIGNATURE OF DECEASED (None)</p>		<p>46. SIGNATURE OF DECEASED (None)</p>		<p>47. SIGNATURE OF DECEASED (None)</p>		<p>48. SIGNATURE OF DECEASED (None)</p>	
<p>49. SIGNATURE OF DECEASED (None)</p>		<p>50. SIGNATURE OF DECEASED (None)</p>		<p>51. SIGNATURE OF DECEASED (None)</p>		<p>52. SIGNATURE OF DECEASED (None)</p>	
<p>53. SIGNATURE OF DECEASED (None)</p>		<p>54. SIGNATURE OF DECEASED (None)</p>		<p>55. SIGNATURE OF DECEASED (None)</p>		<p>56. SIGNATURE OF DECEASED (None)</p>	
<p>57. SIGNATURE OF DECEASED (None)</p>		<p>58. SIGNATURE OF DECEASED (None)</p>		<p>59. SIGNATURE OF DECEASED (None)</p>		<p>60. SIGNATURE OF DECEASED (None)</p>	
<p>61. SIGNATURE OF DECEASED (None)</p>		<p>62. SIGNATURE OF DECEASED (None)</p>		<p>63. SIGNATURE OF DECEASED (None)</p>		<p>64. SIGNATURE OF DECEASED (None)</p>	
<p>65. SIGNATURE OF DECEASED (None)</p>		<p>66. SIGNATURE OF DECEASED (None)</p>		<p>67. SIGNATURE OF DECEASED (None)</p>		<p>68. SIGNATURE OF DECEASED (None)</p>	
<p>69. SIGNATURE OF DECEASED (None)</p>		<p>70. SIGNATURE OF DECEASED (None)</p>		<p>71. SIGNATURE OF DECEASED (None)</p>		<p>72. SIGNATURE OF DECEASED (None)</p>	
<p>73. SIGNATURE OF DECEASED (None)</p>		<p>74. SIGNATURE OF DECEASED (None)</p>		<p>75. SIGNATURE OF DECEASED (None)</p>		<p>76. SIGNATURE OF DECEASED (None)</p>	
<p>77. SIGNATURE OF DECEASED (None)</p>		<p>78. SIGNATURE OF DECEASED (None)</p>		<p>79. SIGNATURE OF DECEASED (None)</p>		<p>80. SIGNATURE OF DECEASED (None)</p>	
<p>81. SIGNATURE OF DECEASED (None)</p>		<p>82. SIGNATURE OF DECEASED (None)</p>		<p>83. SIGNATURE OF DECEASED (None)</p>		<p>84. SIGNATURE OF DECEASED (None)</p>	
<p>85. SIGNATURE OF DECEASED (None)</p>		<p>86. SIGNATURE OF DECEASED (None)</p>		<p>87. SIGNATURE OF DECEASED (None)</p>		<p>88. SIGNATURE OF DECEASED (None)</p>	
<p>89. SIGNATURE OF DECEASED (None)</p>		<p>90. SIGNATURE OF DECEASED (None)</p>		<p>91. SIGNATURE OF DECEASED (None)</p>		<p>92. SIGNATURE OF DECEASED (None)</p>	
<p>93. SIGNATURE OF DECEASED (None)</p>		<p>94. SIGNATURE OF DECEASED (None)</p>		<p>95. SIGNATURE OF DECEASED (None)</p>		<p>96. SIGNATURE OF DECEASED (None)</p>	
<p>97. SIGNATURE OF DECEASED (None)</p>		<p>98. SIGNATURE OF DECEASED (None)</p>		<p>99. SIGNATURE OF DECEASED (None)</p>		<p>100. SIGNATURE OF DECEASED (None)</p>	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

0047

048

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland c. LENGTH OF STAY IN 1b 36 yrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 229 Cecelia St.				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland d. STREET ADDRESS 229 Cecelia St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) Harry G. Minnigh		4. DATE OF DEATH Month Jan. Day 31 Year 1961		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 25, 1883		9. AGE (In years last birthday) 77 yrs. IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during retired life, even if retired) Telegraph Operator Railroad				10b. KIND OF BUSINESS OR INDUSTRY Railroad				11. BIRTHPLACE (County & State, or foreign country) Duncansville, Pa.				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harry Minnigh						14. MOTHER'S MAIDEN NAME Carrie ?							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 705-05-8123				17. INFORMANT Gilbert Minnigh, Cumberland, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO (b) myocarditis DUE TO (c) arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												INTERVAL BETWEEN ONSET AND DEATH 2 yrs 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)													
20c. TIME OF INJURY Month, Day, Year Jan 31, 1961 Hour a.m. 19 p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) June 29, 1961				20f. (City or town) June 29, 1961	
21. I certify that (I) (this hospital) attended the deceased from June 29, 1961 to Jan 31, 1961; that (I) (we) last saw the deceased alive on Jan 29, 1961, and that death occurred at 11 P.M. from the causes and on the date stated above.													
22a. SIGNATURE Clay E. Durrett						22b. DATE SIGNED 2/1/61							
22c. PHYSICIAN'S NAME (Type) Dr. Clay E. Durrett, M.D.						22d. ADDRESS 236 1/2 Cor. Cumberland Rd							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 2-3-1961				23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park				23d. LOCATION (City, town or county) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.						25a. REC'D BY REGISTRAR DATE FEB 6 '61						25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60

69943

643

Alfred W.

Harvard

Allegany

Camdenland

58 yrs.

Camdenland

San Cecilia St.

San Cecilia St.

Jan. 21 1961

G. Minnigh

Harry

Nov. 25, 1953

Nov. 25, 1953

Democrat, F. J.

Democrat, F. J.

Carrie

Harry Minnigh

1

Post-Office-Inspector Minnigh, Camdenland, N.J.

no

Dr. Gray E. Bartlett, D. O.

Hillcrest Hospital East Camdenland, N.J.

Nov. 2-1961

James F. Bartlett, D. O., Camdenland, N.J.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

049 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

60048

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing		c. LENGTH OF STAY IN 1b 65 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Main Street				d. STREET ADDRESS Main Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JAMES Middle MONAHAN Last MONAHAN				4. DATE OF DEATH Month 1/7/1960 Day 19 Year 19			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/21/1895	
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY Lonaconing		11. BIRTHPLACE (State or foreign country) U.S.A.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John Monahan				14. MOTHER'S MAIDEN NAME Mary Freal			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes-World War 1				16. SOCIAL SECURITY NO. 220-10-1061		17. INFORMANT Address Mrs. Anna Monahan, Lonaconing, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 42202 Acute Cardiac Dilatation Conditions, if any, which gave rise to immediate cause (b) myocardial insufficiency (c) 7 years</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (WIFE)</p> </div> <div style="width: 35%;"> <p>INTERVAL BETWEEN ONSET AND DEATH Sudden</p> </div> </div>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE WOMcLane				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) WOMcLane MO				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Firstburg Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/10/1960		22c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery		22d. LOCATION (City, town, or county) (State) Lonaconing, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE George Czekhon, Lonaconing, Md				24a. REC'D BY REGISTRAR JAN 10 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

00044

MASSACHUSETTS DEPARTMENT OF HEALTH - BARNHART 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES J. JONES		45		M		W		10-10-1910		Barnstable, Mass.	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		PREVIOUS ILLNESS		CAUSE OF DEATH	
100 North Street, Barnstable, Mass.		Farmer		High School		Married		None		Heart Disease	
DATE OF BIRTH		PLACE OF BIRTH		DATE OF MARRIAGE		NAME OF SPOUSE		DATE OF INTERMENT		PLACE OF INTERMENT	
10-10-1910		Barnstable, Mass.		10-10-1910		Mary J. Jones		10-10-1910		Barnstable, Mass.	
<p>Signature of Medical Examiner: <i>James J. Jones</i></p> <p>Signature of Coroner: <i>James J. Jones</i></p>											

011-06

VR A15 (4)
15M 9/60

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

051

CERTIFICATE OF DEATH

C0050

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE W. VA b. COUNTY MINERAL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LUKE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PIEDMONT			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CITY BUILDING				d. STREET ADDRESS 58 Third St. 85 X-3			
3. NAME OF DECEASED (Type or print) First Middle Last JOHN J ose MUNSIE				4. DATE OF DEATH Month Day Year JAN 4 19 61			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 17, 1894		9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAINTENANCE FOR.		10b. KIND OF BUSINESS OR INDUSTRY CITY OF LUKE		11. BIRTHPLACE (State or foreign country) PIEDMONT, W. VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES MUNSIE				14. MOTHER'S MAIDEN NAME AMELIA JOSE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 219-14-5604		17. INFORMANT MRS LENA MUNSIE Address 58-3rd St Piedmont W. Va			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH 7 days			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1, 1961 , to Jan 4, 1961 , that I last saw the deceased alive on Jan 2, 1961 , and that death occurred at 7:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE James H. Wolverton M.D.							
PHYSICIAN'S NAME (Type) Jas. H. Wolverton Md. Green St. Piedmont, W. Va. 1/4/61							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1/6/61		22c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery		22d. LOCATION (City, town, or county) (State) Keyser R.D. W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE W. H. Fredlock Jr. ADDRESS Piedmont, W. Va.				24a. REC'D BY REGISTRAR DATE JAN 9 '61		24b. REGISTRAR'S SIGNATURE Clifford S. Kline	

CERTIFICATE OF DEATH

PLACE OF DEATH		MARRIAGE	
1. Name of deceased		2. Date of marriage	
3. Name of informant		4. Name of informant	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

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052
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
Certificate of Death
Item 4 - Film 261-2-20-61 et

C0051

1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport c. LENGTH OF STAY IN 1b 63 Yrs d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 319 Vine		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport d. STREET ADDRESS 319 Vine e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Minnie Middle Nicolo Last Nicolo		4. DATE OF DEATH Month January Day 2 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 17, 1877
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Aden Duckworth	
14. MOTHER'S MAIDEN NAME Dorcas E. Wilt		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. no		17. INFORMANT Bruce Nicolo-Westernport, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO atherosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Diabetes mellitus DUE TO (c) Diabetes mellitus		INTERVAL BETWEEN ONSET AND DEATH 5 days 25 yrs. 31 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from October 1960 to Jan 2, 1961 , that (I) (we) last saw the deceased alive on 1-1-1961 , and that death occurred at 5:4 M. from the causes and on the date stated above.			
22a. SIGNATURE William W. Lesh		22b. DATE SIGNED 1-3-61	
22c. PHYSICIAN'S NAME (Type) William W. Lesh		22d. ADDRESS Westernport, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/4/61	
23c. NAME OF CEMETERY OR CREMATORY Philos		23d. LOCATION (City, town, or county) (State) Westernport Md.	
24. FUNERAL DIRECTOR'S SIGNATURE E. J. Boal		25a. REC'D BY REGISTRAR JAN 4 1961	
25b. REGISTRAR'S SIGNATURE Arthur S. Howard		DATE	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
053											
CERTIFICATE OF DEATH											
C0052											
1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland c. LENGTH OF STAY IN 1b 59 yrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 219 W. Offutt St.						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 02 Cumberland d. STREET ADDRESS 219 W. Offutt St. a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Millard Russell E. Owens						4. DATE OF DEATH Jan. 31 19 61					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 12, 1901		9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist Helper				10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (County & State, or foreign country) Cumberland, Md.				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Oliver P. Owens						14. MOTHER'S MAIDEN NAME Jennie Troutman					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no						16. SOCIAL SECURITY NO. no					
17. INFORMANT Mrs. Millard Owens, Cumberland, Md.						Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 420.0 DUE TO (b) Arteriosclerotic Heart disease, with cardiomegaly, recent myocardial infarction (Aug 1960) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus; possible cancer (could not be diagnosed) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH 2 months 3 years (?)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from September 2, 1960 to January 31, 1961 , that (I) (we) last saw the deceased alive on January 26th 1961 , and that death occurred at 7 p.m. from the causes and on the date stated above.											
22a. SIGNATURE Wyand F. Doerner, Jr.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2-1-61			
22c. PHYSICIAN'S NAME (Type) Wyand F. Doerner, Jr., M.D.						22d. ADDRESS Algonquin Hotel, Cumberland, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-3-1961		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park				23d. LOCATION (City, town or county) Cumberland, Md. (State)			
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.						ADDRESS		25a. REC'D BY REGISTRAR FEB 6 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

00052

Allegany

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Cambridgeshire

22 yrs.

110 F. Street

Jan. 21

William Russell F. Owens

Feb. 12, 1901

White

Cambridgeshire, Md.

Harford

Clinton Hill

James T. Owens

Cliver F. Owens

Mrs. William Owens, Cambridgeshire, Md.

no

2 months

Cooperative Home - Baltimore

Attest: I have read the foregoing and find it correct.
James T. Owens (and 1900) 2 years (?)

Witness: I have read the foregoing and find it correct.

September 25, 1901

January 28, 1901

2-1-11

Alfred H. Hore, Cambridgeshire, Md.

Lynd F. Hore, Jr., R.D.

Ernest Memorial Park, Cambridgeshire, Md.

2-2-1901

James T. Owens

James F. Hore, Cambridgeshire, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
054
CERTIFICATE OF DEATH
C0053

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport				c. LENGTH OF STAY IN 1b 1 Yr.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport 43	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 214 Hammond				d. STREET ADDRESS 214 Hammond		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Jesse Middle Potter Last Potter				4. DATE OF DEATH Month Jan Day 14 Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 9, 1890	
9. AGE (In years lost birthday) 71 yrs.		IF UNDER 1 YEAR Months 7 Days 14 Hours 14 Min.		IF UNDER 24 HRS. Months 7 Days 14 Hours 14 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Civil engineer				10b. KIND OF BUSINESS OR INDUSTRY Contracting Co.		11. BIRTHPLACE (State or foreign country) Littleton, Mass.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John S. Potter				14. MOTHER'S MAIDEN NAME Adelaide Marshall			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W.W.1				16. SOCIAL SECURITY NO. 023-057456		17. INFORMANT John S. Potter-Westernport, Md. Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Pruritus Congestive heart failure. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 2 yr. DUE TO Arteriosclerotic heart disease (c) 2 yr.				INTERVAL BETWEEN ONSET AND DEATH 2 weeks			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension + Cerebral Atrophy				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Westernport, Md.				(County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 12/14/61 to Jan 14, 1961 , that (I) (we) last saw the deceased alive on 1/14/61 , and that death occurred at PM , from the causes and on the date stated above.							
22a. SIGNATURE William W. Lesh				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) William W. Lesh				22d. ADDRESS Main St. Westernport, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 1/16/61		23c. NAME OF CEMETERY OR CREMATORY Lee Crematory-Washington, D.C.		23d. LOCATION (City, town, or county) (State) Concord, Mass	
24. FUNERAL DIRECTOR'S SIGNATURE E. J. Boal				ADDRESS Westernport, Md.		25a. REC'D BY REGISTRAR DATE JAN 17 '61	
				25b. REGISTRAR'S SIGNATURE Charles S. Knead			

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00054

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN lb Lifetime		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 142 E. College Ave.				d. STREET ADDRESS 142 E. College Ave.			
3. NAME OF DECEASED (Type or print) First James Middle Lindley Last Rank				4. DATE OF DEATH Month January Day 16th Year 19 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Oct. 22nd, 1895	
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months 65 Days 65 Hours 65 Min. 65		IF UNDER 24 HRS. Months 65 Days 65 Hours 65 Min. 65			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Journalist		10b. KIND OF BUSINESS OR INDUSTRY Journalistic		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Rank				14. MOTHER'S MAIDEN NAME Mary Jane Dando			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W.1		17. INFORMANT Address Miss Sarah Dando, 97 Hill St., F'bg. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Congestion and Edema, Marked INTERVAL BETWEEN ONSET AND DEATH 2-3 Hrs. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Aortic Stenosis, Myocardial Hypertrophy, Marked Years (c) Rheumatic valvulitis with calcification Years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE W O McLane M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) W. O. McLane,				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-21-61		22c. NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE L. R. Dwyer				ADDRESS Frostburg, Md.		24a. REC'D BY REGISTRAR DATE JAN 23 '61	
						24b. REGISTRAR'S SIGNATURE Carling S. Hines	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10 MEDICAL EXAMINER'S CERTIFICATE OF DEATH	
NAME OF DECEASED: <u>John Doe</u>	
SEX: <u>Male</u>	
AGE: <u>45</u>	
DATE OF DEATH: <u>1945-10-15</u>	
PLACE OF DEATH: <u>Home</u>	
CAUSE OF DEATH: <u>Heart Disease</u>	
MANNER OF DEATH: <u>Natural</u>	
SIGNATURE OF EXAMINER: <u>Dr. J. K. Smith</u>	
OFFICE OF THE MEDICAL EXAMINER: <u>Baltimore, Md.</u>	
DATE OF EXAMINATION: <u>1945-10-16</u>	
TIME OF EXAMINATION: <u>10:00 AM</u>	
PLACE OF EXAMINATION: <u>Home</u>	
NAME OF DECEASED: <u>John Doe</u>	
SEX: <u>Male</u>	
AGE: <u>45</u>	
DATE OF DEATH: <u>1945-10-15</u>	
PLACE OF DEATH: <u>Home</u>	
CAUSE OF DEATH: <u>Heart Disease</u>	
MANNER OF DEATH: <u>Natural</u>	
SIGNATURE OF EXAMINER: <u>Dr. J. K. Smith</u>	
OFFICE OF THE MEDICAL EXAMINER: <u>Baltimore, Md.</u>	
DATE OF EXAMINATION: <u>1945-10-16</u>	
TIME OF EXAMINATION: <u>10:00 AM</u>	
PLACE OF EXAMINATION: <u>Home</u>	

This is a true and correct copy of the original certificate of death as filed in the office of the Medical Examiner, Baltimore, Maryland, on the 16th day of October, 1945.

J. K. Smith, M.D.
 Medical Examiner

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Allegany</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Allegany</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cumberland</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>12 Cumberland</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>109 Offutt St.</i>		d. STREET ADDRESS <i>109 Offutt St.</i>	
3. NAME OF DECEASED (Type or print) <i>Eugenia H Rankin</i>		4. DATE OF DEATH <i>Jan. 4 1961</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 18, 1886</i>
9. AGE (In years last birthday) <i>74</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A</i>		13. FATHER'S NAME <i>William Koontz</i>	
14. MOTHER'S MAIDEN NAME <i>Mary E. Kerns</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) <i>No</i> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Mrs. Helen Rawlings</i> Address <i>Cum. Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerosis</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>4 yrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>June 1960</i> , to <i>Jan. 4, 1961</i> , that I last saw the deceased alive on <i>Jan. 2, 1961</i> , and that death occurred at <i>M</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Clayton G. Burnett</i>		ADDRESS (Street, city or town, state) <i>23669-005 Cumberland Md</i> DATE SIGNED <i>1/5/61</i>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<i>Burial</i>	<i>1/8/61</i>	<i>Rose Hill Cem.</i>	<i>Cumberland Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Louis Stein Inc.</i> ADDRESS <i>Cum. Md</i>		24a. REC'D BY REGISTRAR DATE <i>JAN 9 '61</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Knaus</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

082

1918

1. NAME OF DECEASED <i>JOHN J. BROWN</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>		4. DATE OF BIRTH <i>Jan 15 1873</i>		5. PLACE OF BIRTH <i>Worcester, Mass.</i>		6. US BIRTH REGISTRATION <i>Yes</i>		7. MARITAL STATUS <i>Married</i>		8. OCCUPATION <i>Engineer</i>		9. PLACE OF DEATH <i>Worcester, Mass.</i>		10. CAUSE OF DEATH <i>Heart Disease</i>		11. MEDICAL ATTENDANCE <i>Dr. J. H. Smith</i>		12. BURIAL PLACE <i>St. John's Church</i>		13. SIGNATURE OF REGISTRAR <i>J. H. Smith</i>		14. SIGNATURE OF DECEASED <i>John J. Brown</i>		15. SIGNATURE OF WITNESSES <i>John J. Brown</i>		16. SIGNATURE OF DECEASED <i>John J. Brown</i>		17. SIGNATURE OF DECEASED <i>John J. Brown</i>		18. SIGNATURE OF DECEASED <i>John J. Brown</i>		19. SIGNATURE OF DECEASED <i>John J. Brown</i>		20. SIGNATURE OF DECEASED <i>John J. Brown</i>		21. SIGNATURE OF DECEASED <i>John J. Brown</i>		22. SIGNATURE OF DECEASED <i>John J. Brown</i>		23. SIGNATURE OF DECEASED <i>John J. Brown</i>		24. SIGNATURE OF DECEASED <i>John J. Brown</i>		25. SIGNATURE OF DECEASED <i>John J. Brown</i>		26. SIGNATURE OF DECEASED <i>John J. Brown</i>		27. SIGNATURE OF DECEASED <i>John J. Brown</i>		28. SIGNATURE OF DECEASED <i>John J. Brown</i>		29. SIGNATURE OF DECEASED <i>John J. Brown</i>		30. SIGNATURE OF DECEASED <i>John J. Brown</i>		31. SIGNATURE OF DECEASED <i>John J. Brown</i>		32. SIGNATURE OF DECEASED <i>John J. Brown</i>		33. SIGNATURE OF DECEASED <i>John J. Brown</i>		34. SIGNATURE OF DECEASED <i>John J. Brown</i>		35. SIGNATURE OF DECEASED <i>John J. Brown</i>		36. SIGNATURE OF DECEASED <i>John J. Brown</i>		37. SIGNATURE OF DECEASED <i>John J. Brown</i>		38. SIGNATURE OF DECEASED <i>John J. Brown</i>		39. SIGNATURE OF DECEASED <i>John J. Brown</i>		40. SIGNATURE OF DECEASED <i>John J. Brown</i>		41. SIGNATURE OF DECEASED <i>John J. Brown</i>		42. SIGNATURE OF DECEASED <i>John J. Brown</i>		43. SIGNATURE OF DECEASED <i>John J. Brown</i>		44. SIGNATURE OF DECEASED <i>John J. Brown</i>		45. SIGNATURE OF DECEASED <i>John J. Brown</i>		46. SIGNATURE OF DECEASED <i>John J. Brown</i>		47. SIGNATURE OF DECEASED <i>John J. Brown</i>		48. SIGNATURE OF DECEASED <i>John J. Brown</i>		49. SIGNATURE OF DECEASED <i>John J. Brown</i>		50. SIGNATURE OF DECEASED <i>John J. Brown</i>		51. SIGNATURE OF DECEASED <i>John J. Brown</i>		52. SIGNATURE OF DECEASED <i>John J. Brown</i>		53. SIGNATURE OF DECEASED <i>John J. Brown</i>		54. SIGNATURE OF DECEASED <i>John J. Brown</i>		55. SIGNATURE OF DECEASED <i>John J. Brown</i>		56. SIGNATURE OF DECEASED <i>John J. Brown</i>		57. SIGNATURE OF DECEASED <i>John J. Brown</i>		58. SIGNATURE OF DECEASED <i>John J. Brown</i>		59. SIGNATURE OF DECEASED <i>John J. Brown</i>		60. SIGNATURE OF DECEASED <i>John J. Brown</i>		61. SIGNATURE OF DECEASED <i>John J. Brown</i>		62. SIGNATURE OF DECEASED <i>John J. Brown</i>		63. SIGNATURE OF DECEASED <i>John J. Brown</i>		64. SIGNATURE OF DECEASED <i>John J. Brown</i>		65. SIGNATURE OF DECEASED <i>John J. Brown</i>		66. SIGNATURE OF DECEASED <i>John J. Brown</i>		67. SIGNATURE OF DECEASED <i>John J. Brown</i>		68. SIGNATURE OF DECEASED <i>John J. Brown</i>		69. SIGNATURE OF DECEASED <i>John J. Brown</i>		70. SIGNATURE OF DECEASED <i>John J. Brown</i>		71. SIGNATURE OF DECEASED <i>John J. Brown</i>		72. SIGNATURE OF DECEASED <i>John J. Brown</i>		73. SIGNATURE OF DECEASED <i>John J. Brown</i>		74. SIGNATURE OF DECEASED <i>John J. Brown</i>		75. SIGNATURE OF DECEASED <i>John J. Brown</i>		76. SIGNATURE OF DECEASED <i>John J. Brown</i>		77. SIGNATURE OF DECEASED <i>John J. Brown</i>		78. SIGNATURE OF DECEASED <i>John J. Brown</i>		79. SIGNATURE OF DECEASED <i>John J. Brown</i>		80. SIGNATURE OF DECEASED <i>John J. Brown</i>		81. SIGNATURE OF DECEASED <i>John J. Brown</i>		82. SIGNATURE OF DECEASED <i>John J. Brown</i>		83. SIGNATURE OF DECEASED <i>John J. Brown</i>		84. SIGNATURE OF DECEASED <i>John J. Brown</i>		85. SIGNATURE OF DECEASED <i>John J. Brown</i>		86. SIGNATURE OF DECEASED <i>John J. Brown</i>		87. SIGNATURE OF DECEASED <i>John J. Brown</i>		88. SIGNATURE OF DECEASED <i>John J. Brown</i>		89. SIGNATURE OF DECEASED <i>John J. Brown</i>		90. SIGNATURE OF DECEASED <i>John J. Brown</i>		91. SIGNATURE OF DECEASED <i>John J. Brown</i>		92. SIGNATURE OF DECEASED <i>John J. Brown</i>		93. SIGNATURE OF DECEASED <i>John J. Brown</i>		94. SIGNATURE OF DECEASED <i>John J. Brown</i>		95. SIGNATURE OF DECEASED <i>John J. Brown</i>		96. SIGNATURE OF DECEASED <i>John J. Brown</i>		97. SIGNATURE OF DECEASED <i>John J. Brown</i>		98. SIGNATURE OF DECEASED <i>John J. Brown</i>		99. SIGNATURE OF DECEASED <i>John J. Brown</i>		100. SIGNATURE OF DECEASED <i>John J. Brown</i>	
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MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON, MASS.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH																			
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																			
CERTIFICATE OF DEATH																			
057 60056																			
1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN lb 2 1/2 HRS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Near Oldtown; Md. Rural d. STREET ADDRESS Sulphur Spring Road e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>														
3. NAME OF DECEASED (Type or print) GLEN N ROY REDINGER					4. DATE OF DEATH Month JANUARY Day 4 Year 1961														
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 7, 1896		9. AGE (In years last birthday) 64 yrs.											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sawyer, Retired		10b. KIND OF BUSINESS OR INDUSTRY Saw Mill		11. BIRTHPLACE (County & State, or foreign country) Bedford County, Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.													
13. FATHER'S NAME THOMAS REDINGER					14. MOTHER'S MAIDEN NAME ZELDA DICKEN S														
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. 217-10-6550					17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 4443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Hypertensive Cerebral Vascular Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Leptos Encephalitis										INTERVAL BETWEEN ONSET AND DEATH 4 hours									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)									
21. I certify that (I) (this hospital) attended the deceased from Feb 20, 1953 to Nov 29, 1960 , that (I) (we) last saw the deceased alive on Nov 29, 1960 , and that death occurred at 1:15 AM from the causes and on the date stated above.										22a. SIGNATURE [Signature] M.D.					22b. DATE SIGNED 1/4/61				
22c. PHYSICIAN'S NAME (Type) DR. G. OVERTON HIMMELWRIGHT					22d. ADDRESS 133 VIRGINIA AVE., CUMBERLAND, MD.														
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 7, 1961		23c. NAME OF CEMETERY OR CREMATORY Oldtown Cemetery		23d. LOCATION (City, town or county) Oldtown, Maryland		(State)											
24. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George,					ADDRESS Cumberland, Md.					25a. REC'D BY REGISTRAR JAN 9 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

10058

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ALLEGANY MARYLAND ALLEGANY

OF THE STATE OF MARYLAND

MEMORIAL HOSPITAL

ROY BEDINGER JANUARY 21

MALE WHITE

APRIL 2, 1966

TIMOTHY BEDINGER

MEMORIAL HOSPITAL, ALLEGANY, MD.

1

*Copy of letter to [illegible]
Hypertension Clinic [illegible]*

*Letter to [illegible]
[illegible]*

[illegible signature]
[illegible signature]

DR. A. GENTON WILKINSON, 103 VIRGINIA AVE., GREENSBORO, NC.

DR. J. H. [illegible] [illegible]

GREENSBORO, NC.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND DEPARTMENT OF HEALTH—BALTIMORE, 18

C0057

058

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>79</u> years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sylvan Retreat</u>		d. STREET ADDRESS <u>348 Baltimore Avenue</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Myrtle</u> Middle <u>Eliza</u> Last <u>Reed</u>		4. DATE OF DEATH Month <u>January</u> Day <u>27</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/27/81</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Fazenbaker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Address</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>592 Chronic Myocardial Degeneration</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>450 General arteriosclerosis</u> DUE TO (c) <u>592 Chronic Nephritis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>?</u> <u>?</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Severe psychosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 12</u> , 19 <u>61</u> to <u>Jan 27</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Jan 26</u> , 19 <u>61</u> , and that death occurred at <u>8:15</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>49 Greene St.</u> DATE SIGNED ACTUAL SIGNATURE <u>James E. McLean</u> M.D. <u>James E. McLean</u> PHYSICIAN'S NAME (Type) <u>James E. McLean, M.D.</u> <u>49 Greene Street, Cumberland, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 30, 1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Byron Kight</u> ADDRESS <u>Cumberland, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 30 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Lonaconing		d. STREET ADDRESS 1 Dudley Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HARRY		First		Middle REIBER		Last	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF DEATH 1/13/1961	
9. AGE (In years last birthday) 80		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Kelly Tire Co.		10b. KIND OF BUSINESS OR INDUSTRY Wellersburg, Pa.		11. BIRTHPLACE (State or foreign country) U.S.A.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William Reiber		14. MOTHER'S MAIDEN NAME Matilda Long			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mrs. Gene Evans		Address Lonaconing, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial insufficiency DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease, 15 yrs DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1 min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Post operative: subtotal gastric resection						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 5, 1961 to Jan 13, 1961 , that (I) (we) last saw the deceased alive on Jan 13, 1961 , and that death occurred at 11:15 PM , from the causes and on the date stated above.							
22a. SIGNATURE Alvin J. Walters		22b. DATE SIGNED 1/14/61					
22c. PHYSICIAN'S NAME (Type) Alvin J. Walters		22d. ADDRESS Frostburg, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/16/1961		23c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery		23d. LOCATION (City, town, or county) (State) Moscow, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHHORN		ADDRESS LONA CONING, MD.		25a. REC'D BY REGISTRAR DATE JAN 16 '61		25b. REGISTRAR'S SIGNATURE Charles E. Thomas	

CERTIFICATE OF DEATH

029

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00059

060

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND 11 DAYS c. LENGTH OF STAY IN 1b 11 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND d. STREET ADDRESS 101 PARK STREET a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last RAYMOND REYNOLDS				4. DATE OF DEATH Month Day Year JANUARY 30 1961											
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 10, 1893		9. AGE (In years last birthday) 67 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Machinist				10b. KIND OF BUSINESS OR INDUSTRY B. & O. Rwy.		11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME LAWSON REYNOLDS				14. MOTHER'S MAIDEN NAME MARY BENNER											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW # 1				16. SOCIAL SECURITY NO. WW # 1				17. INFORMANT Address MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Disease 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH 5 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Urinary calculi								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3-19-1950 to 1-30-1961 that (I) (we) last saw the deceased alive on 1-29-1961 , and that death occurred at 1:30 AM from the causes and on the date stated above.															
22a. SIGNATURE <i>R. W. Ballin</i> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 62 GREENE ST., CUMBERLAND, MD.				22b. DATE SIGNED 1-30-61							
22c. PHYSICIAN'S NAME (Type) DR. R. W. BALLIN				23a. BURIAL, CREMATION, REMOVAL (Specify) Burial						23b. DATE THEREOF Feb. 1, 1961		23c. NAME OF CEMETERY OR CREMATORY Sunset Mem. Park		23d. LOCATION (City, town or county) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George				ADDRESS Cumberland, Md.				25a. REC'D BY REGISTRAR DATE FEB 3 '61		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1, 2, 3, and 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1, 2, 3, and 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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ALLIANCE

MARYLAND

ALLIANCE

CUMBERLAND

11 DAYS

CUMBERLAND

101 PARK STREET

MEMORIAL HOSPITAL

61 JANUARY 30

REYNOLDS

REYNOLDS

MARCH 10, 1932

MALE WHITE

U.S.A.

CUMBERLAND, MARYLAND

U.S.A.

U.S.A.

MARY FENNER

LAWSON REYNOLDS

1

MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND

U.S.A.

1 - 10 - 30

1:30 AM

1 - 10 - 30

65 GREENE ST., CUMBERLAND, MD.

DR. R. W. BULLIN

U.S.A. 1 - 10 - 30

U.S.A. 1 - 10 - 30

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

061

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

C0060

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG	
c. LENGTH OF STAY IN 1b LIFE		d. STREET ADDRESS 184 W. MAIN ST.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 184 W. MAIN ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First RUTH Middle C. Last RUFFO		4. DATE OF DEATH Month JANUARY Day 4 Year 1961	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 31, 1915
9. AGE (In years last birthday) 45 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE ENTLER		14. MOTHER'S MAIDEN NAME ELSIE ROBINSON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) UNKNOWN		17. INFORMANT Address WM. C. DAVIS, JR., FROSTBURG, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 199.2 DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12/23 19 61 , to 1/4 19 61 , that (I) (we) last saw the deceased alive on 12/30 19 61 , and that death occurred at 2:00 PM from the causes and on the date stated above.			
22a. SIGNATURE Leo H. Ley, Jr.		22b. DATE SIGNED 1/4/61	
22c. PHYSICIAN'S NAME (Type) LEO. H. LEY, M. D.		22d. ADDRESS 456 N. CENTRE ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1-6-61	
23c. NAME OF CEMETERY OR CREMATORY ST. MICHAEL'S CEMETERY		23d. LOCATION (City, town, or county) (State) FROSTBURG, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE L. H. Burst		25a. REC'D BY REGISTRAR DATE JAN 6 '61	
ADDRESS FROSTBURG, MD.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

may be required by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

062

CERTIFICATE OF DEATH

C0061

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG				c. LENGTH OF STAY IN 1b 4 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MINERS HOSPITAL				d. STREET ADDRESS 11x-2			
3. NAME OF DECEASED (Type or print) First RANDOLPH Middle C. Last RUSH				4. DATE OF DEATH Month JANUARY Day 15 Year 1961			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 6, 1909		9. AGE (In years last birthday) 51 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TIRE BUILDER		10b. KIND OF BUSINESS OR INDUSTRY KELLY-SPGFD. CO.		11. BIRTHPLACE (State or foreign country) INDIANA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JACOB RUSH				14. MOTHER'S MAIDEN NAME HANNAH STREID			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 219-03-8348		17. INFORMANT Address ANTHONY RUSH, FROSTBURG, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 570-5 DUE TO Intestinal Obstruction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Extensive Adhesions DUE TO (c) 3 years INTERVAL BETWEEN ONSET AND DEATH 2 days - 3 years						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 12 1961, to Jan 12 1961, that (I) (we) last saw the deceased alive on Jan 12 1961, and that death occurred at 1:37 P.M. from the causes and on the date stated above.							
22a. SIGNATURE W. O. McLane		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Jan 17/1961			
22c. PHYSICIAN'S NAME (Type) W. O. McLANE, M. D.		22d. ADDRESS E. MAIN ST., FROSTBURG, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1-18-1961		23c. NAME OF CEMETERY OR CREMATORY McGAHEYSVILLE CEMETERY		23d. LOCATION (City, town, or county) (State) McGAHEYSVILLE, VA.	
24. FUNERAL DIRECTOR'S SIGNATURE J. R. Duret ADDRESS FROSTBURG, MD.				25a. REC'D BY REGISTRAR DATE JAN 17 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Klaus	

(M)

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LABORATORY OF THE DEPARTMENT OF HEALTH
IN RESPONSE TO REQUEST FOR INFORMATION - JANUARY 17, 1961

CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00062

Reg. Dist. No.

063

1. PLACE OF DEATH a. COUNTY <u>ALLEGANY</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ALLEGANY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u>			c. LENGTH OF STAY IN 1b <u>10 MINUTES</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 CUMBERLAND</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SACRED HEART HOSPITAL</u>				d. STREET ADDRESS <u>139 BOND STREET</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>NANNIE</u> Middle <u>PEARL</u> Last <u>SHARRETT</u>				4. DATE OF DEATH Month <u>JANUARY</u> Day <u>25</u> Year <u>1961</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/23/1893</u>		9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>WEST VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN BARRY</u>				14. MOTHER'S MAIDEN NAME <u>Eliza Spencer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>212 24 0083</u>		17. INFORMANT <u>CHART</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1</u> <u>CORONARY OCCLUSION, LEFT</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY SCLEROSIS WITH THROMBOSIS</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>11 hr.</u> ****	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>Benedict Skitarelic, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>January 25, 1961</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 27, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Byron Knight</u> <u>Cumberland, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 27 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar for burial, cremation, or removal.
 VS. A15ME(5)
 SM 9/55

M

062

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2

08

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

064

CERTIFICATE OF DEATH

00063

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u> c. LENGTH OF STAY IN 1b <u>1wk.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Miners Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u> d. STREET ADDRESS <u>7 Ormond Street</u> a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>ALLIE SHEARER</u>		4. DATE OF DEATH 1 28 19 61		5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>11/20/1891</u> 9. AGE (In years last birthday) <u>69</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Frostburg, Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Robert Shearer</u> 14. MOTHER'S MAIDEN NAME <u>Mollie Farrady</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>Miss Ruth Paupe, 227 Henderson Ave.,</u> Address <u>Cumberland, Frostburg, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO (b) <u>arterio-sclerotic heart disease</u> DUE TO (c) <u>Coronary insufficiency</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>1-20</u> , 19 <u>61</u> , to <u>1-28</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>1-28</u> , 19 <u>61</u> , and that death occurred at <u>6 P.M.</u> from the causes and on the date stated above.					
22a. SIGNATURE <u>H.C. Diehl</u> 22b. DATE SIGNED <u>1/30/61</u>		22c. PHYSICIAN'S NAME (Type) <u>H.C. Diehl, M.D.</u> 22d. ADDRESS <u>Frostburg, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>12/1/61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Frostburg Memorial Park</u> 23d. LOCATION (City, town or county) (State) <u>Frostburg Md.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Hafer Funeral Home</u> 25a. REC'D BY REGISTRAR <u>FEB 6 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60

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[Illegible text]

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60064

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (If deceased lived. If institution: Residence before admission) a. STATE		b. COUNTY	
Allegany				Maryland		Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Frostburg		7 Hrs.		Frostburg			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
Miners Hospital				Route 2,			
3. NAME OF DECEASED (Type or print)		First		Middle		Last	
		John		Carter		Shryock	
4. DATE OF DEATH		Month		Day		Year	
		January		20th,		19 61	
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Jan. 28th, 1889	
9. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
71 yrs.		Months		Days		Hours	
						Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Ret.-Engineer		State Roads		Maryland		USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME					
Richard F. Shryock		Maggie Bell					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
		218-248303		Mrs. Nellie D. Shryock, Rt. 2, F'bg. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		Major myocardial infarction Coronary Occlusion due to arteriosclerosis Heart		INTERVAL BETWEEN ONSET AND DEATH 4 days 10 yrs?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		NONE		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
1/20 1961		While at work		Frostburg		Allegany Md.	
21. I certify that (I) (this hospital) attended the deceased from 1/27 1961, to 1/20 1961, that (I) (we) last saw the deceased alive on 1/20 1961, and that death occurred at 5:20 AM, from the causes and on the date stated above.							
22a. SIGNATURE Martin M. Rothstein M.D.		22b. DATE SIGNED 1/21/61		22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
				Martin M. Rothstein		48 Broadway, Frostburg, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
Burial		1-23-61		F'bg. Memorial Park		Frostburg, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE L. P. Hurst		ADDRESS Frostburg, Md.		25a. REC'D BY REGISTRAR DATE JAN 25 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Hanna	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

006

CERTIFICATE OF DEATH

00065

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			
c. LENGTH OF STAY IN 1b 8 DAYS				d. STREET ADDRESS 1 79 GREENE STREET			
d. NAME OF HOSPITAL OR INSTITUTION (If hospital, give full name and address) MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CORA Middle HELEN Last SLOAN				4. DATE OF DEATH Month JANUARY Day 21 Year 19 61			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-23-1899	
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) FROSTBURG, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME JOHN H. SLOAN				14. MOTHER'S MAIDEN NAME EMMA HICE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) NO				16. SOCIAL SECURITY NO. NONE			
17. INFORMANT MEMORIAL HOSPITAL-CUMBERLAND, MD.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastric Hemorrhage 199.2 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) 199.2 DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Metastatic Carcinoma							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/13 19 61 to 1/21 19 61 , that (I) (we) last saw the deceased alive on 1/21 19 61 , and that death occurred at 6:08 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Leo H. Ley, Jr. M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1/24/61	
22c. PHYSICIAN'S NAME (Type) DR. LEO H. LEY JR.				22d. ADDRESS 456 NORTH CENTRE STREET			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 24, 1961		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town or county) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Byron Knight				ADDRESS Cumberland, Md.		25a. REC'D BY REGISTRAR DATE JAN 25 '61	
				25b. REGISTRAR'S SIGNATURE Arthur S. Hance			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files or for burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00066

Reg. Dist. No.

067

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> <u>02</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sacred Heart</u>				d. STREET ADDRESS <u>318 Md. Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Travis</u> Middle <u>W.</u> Last <u>Smith</u>				4. DATE OF DEATH Month <u>January</u> Day <u>25</u> Year <u>1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 18, 1892</u>		9. AGE (In years last birthday) <u>68</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Janitor</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Harmon Smith</u>			14. MOTHER'S MAIDEN NAME <u>Joann</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>2405 6336</u> <u>Unknown</u>		17. INFORMANT <u>Wife Alice</u> Address <u>Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction, left; old and recent</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary occlusion</u> DUE TO (c) <u>Sclerotic Sclerosis with thrombosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>36 Hrs.</u> <u>11</u> <u>--</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Benedict Skitaralic</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>Dr. B. Skitaralic</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>January 25, 1961</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 28, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sunset Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Byron Kight</u>				ADDRESS <u>Cumberland, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 30 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
 1-00000

NAME OF DECEASED: _____
 SEX: _____ AGE: _____
 DATE OF BIRTH: _____
 PLACE OF BIRTH: _____
 OCCUPATION: _____
 MARITAL STATUS: _____
 EDUCATION: _____
 RELIGION: _____
 RACE: _____
 COLOR: _____
 HEIGHT: _____
 WEIGHT: _____
 BUILD: _____
 HAIR: _____
 EYES: _____
 SKIN: _____
 TENDRILS: _____
 TEETH: _____
 HEARING: _____
 VISION: _____
 TASTE: _____
 SMELL: _____
 TOUCH: _____
 PAIN: _____
 TEMPERATURE: _____
 PULSE: _____
 RESPIRATION: _____
 BLOOD PRESSURE: _____
 BLOOD SUGAR: _____
 BLOOD CHOLESTEROL: _____
 BLOOD URIC ACID: _____
 BLOOD ALKALINITY: _____
 BLOOD ACIDITY: _____
 BLOOD PHOSPHORUS: _____
 BLOOD CALCIUM: _____
 BLOOD IRON: _____
 BLOOD COPPER: _____
 BLOOD ZINC: _____
 BLOOD MANGANESE: _____
 BLOOD NICKEL: _____
 BLOOD SILICON: _____
 BLOOD BORON: _____
 BLOOD FLUORINE: _____
 BLOOD IODINE: _____
 BLOOD BROMINE: _____
 BLOOD CHLORINE: _____
 BLOOD SULFUR: _____
 BLOOD PHOSPHORUS: _____
 BLOOD CALCIUM: _____
 BLOOD IRON: _____
 BLOOD COPPER: _____
 BLOOD ZINC: _____
 BLOOD MANGANESE: _____
 BLOOD NICKEL: _____
 BLOOD SILICON: _____
 BLOOD BORON: _____
 BLOOD FLUORINE: _____
 BLOOD IODINE: _____
 BLOOD BROMINE: _____
 BLOOD CHLORINE: _____
 BLOOD SULFUR: _____

CAUSE OF DEATH: _____
 MANNER OF DEATH: _____
 PLACE OF DEATH: _____
 TIME OF DEATH: _____
 DATE OF DEATH: _____
 SIGNATURE OF EXAMINER: _____
 TITLE OF EXAMINER: _____
 OFFICE OF EXAMINER: _____
 COUNTY OF EXAMINER: _____
 STATE OF EXAMINER: _____

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

068 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00067

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Vale</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1077 National Highway</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LaVale</u> d. STREET ADDRESS <u>1077 National Highway</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																																																							
3. NAME OF DECEASED (Type or print) First <u>JOSEPH</u> Middle <u>IRDELL</u> Last <u>SNOW, SR.</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>28,</u> Year <u>1961</u>																																																							
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Apr. 9, 1897</u>		9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.																																															
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Watch maker & jewelry</u>				10b. KIND OF BUSINESS OR INDUSTRY 				11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>																																															
13. FATHER'S NAME <u>Irdell Snow</u>						14. MOTHER'S MAIDEN NAME <u>Mary Jane Vaughn</u>																																																					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes <input type="checkbox"/> No <input type="checkbox"/> <u>W War I</u>				16. SOCIAL SECURITY NO. 				17. INFORMANT Address																																																			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <table style="width: 100%;"> <tr> <td colspan="10"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> </td> <td colspan="2"> INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u> </td> </tr> <tr> <td colspan="10"> DUE TO <u>420.1</u> </td> <td colspan="2"></td> </tr> <tr> <td colspan="10"> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY SCLEROSIS</u> </td> <td colspan="2"></td> </tr> <tr> <td colspan="10"> DUE TO (c) </td> <td colspan="2"></td> </tr> </table>												PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u>										INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u>		DUE TO <u>420.1</u>												Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY SCLEROSIS</u>												DUE TO (c)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u>										INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u>																																																	
DUE TO <u>420.1</u>																																																											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY SCLEROSIS</u>																																																											
DUE TO (c)																																																											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																																																											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																																																							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)																																																			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>																																																											
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D. EXAMINER'S NAME (Type) <u>Benedict Skitarelic, M.D.</u>						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>January 28, 1961</u>																																																					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Jan 31, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Restlawn Burial Park</u>				22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>																																																	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Hafer</u>						ADDRESS <u>Cumberland, Maryland</u>																																																					
24a. REC'D BY REGISTRAR DATE <u>FEB 3 '61</u>						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Haas</u>																																																					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate in the "pending" envelope, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar, or to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

069 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00068

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE W. Va. b. COUNTY Mineral ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b ***----		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ridgeley,			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL--DOA				d. STREET ADDRESS 167 Main St.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GEORGE Middle OSCAR Last SPANGLER				4. DATE OF DEATH Month Jan. Day 24, Year 19 61			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 19, 1909		9. AGE (In years and birthday) 51 yrs.	IF UNDER 1 YEAR Months 0 Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY B. & O. Rwy.		11. BIRTHPLACE (State or foreign country) Ridgeley, W. Va.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George W. Spangler				14. MOTHER'S MAIDEN NAME Elizabeth Everett			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No,		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Rosalie B. Spangler 167 Main St., Ridgeley, W. Va.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION, RIGHT 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY SCLEROSIS WITH THROMBOSIS DUE TO (c) ---							INTERVAL BETWEEN ONSET AND DEATH 24 Hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		January 24, 1961	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/27/61		22c. NAME OF CEMETERY OR CREMATORY Queens Point Cem.		22d. LOCATION (City, town, or county) (State) Keyser, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George				24a. REC'D BY REGISTRAR JAN 30 '61		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar. If no burial, cremation or removal.

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
070
CERTIFICATE OF DEATH

00069

1. PLACE OF DEATH o. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD. c. LENGTH OF STAY IN lb 2 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR IN MEMORIAL HOSPITAL MEMORIAL & WARWICK AVE.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ADAMSTOWN, MARYLAND d. STREET ADDRESS 10X-2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First NELLIE Middle W. Last SPECHT		4. DATE OF DEATH Month JANUARY Day 13 Year 19 61				
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPTEMBER 3, 1895	9. AGE (In years lost birthday) yrs. 65	IF UNDER 1 YEAR Months 65	IF UNDER 24 HRS. Days 65 Hours 65 Min. 65
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Hood College & Home for the Aged		11. BIRTHPLACE (State or foreign country) DOUBS, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME GEORGE J. SPECHT			14. MOTHER'S MAIDEN NAME ANNAH E. SMITH			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-18-2593		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of colon with 153-8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) perforation and peritonitis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arterio-sclerotic cerebral vascular disease INTERVAL BETWEEN ONSET AND DEATH Approx 2 yrs Approx 2 wks						
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				
20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Jan 11, 1961 , to Jan 13, 1961 , that (I) (we) last saw the deceased alive on Jan 13, 1961 , and that death occurred at 3:45 PM from the causes and on the date stated above.						
22a. SIGNATURE Wylie M Fawcett		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Jan 14, 1961		
22c. PHYSICIAN'S NAME (Type) DR. WYLIE FAW		22d. ADDRESS 122 SOUTH CENTRE, ST., CUMBERLAND, MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-16-61		23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		
23d. LOCATION (City, town, or county) (State) Frederick, Maryland		24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland ADDRESS				
25a. REC'D BY REGISTRAR DATE JAN 18 '61		25b. REGISTRAR'S SIGNATURE James L. Brown				

CERTIFICATE OF DEATH

1910

1910

NAME OF DECEASED: HARRY AND

RESIDENCE: 104 STONE, HARRY AND

DECEASED AT: MEMORIAL HOSPITAL

DATE OF DEATH: JANUARY 13, 1910

AGE: 31 YEARS

SEX: FEMALE

CAUSE OF DEATH: GEORGE J. CHENEY

PLACE OF DEATH: MEMORIAL HOSPITAL, OAKLAND, CALIF.



1-10-11

1-10-11

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
071 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

C0070

Storms

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MIDLOTHIAN				c. LENGTH OF STAY IN lb 1 yr			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS MIDLOTHIAN			
3. NAME OF DECEASED (Type or print) First RETA Middle OPAL Last STURMS				4. DATE OF DEATH Month 1 Day 21 Year 1961			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JAN. 31, 1913	
9. AGE (In years last birthday) 47 yrs.		IF UNDER 1 YEAR Months 21 Days 19		IF UNDER 24 HRS. Hours 19 Min.		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK				10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME WILLIAM HARRIS			
14. MOTHER'S MAIDEN NAME NAOMI MURPHY				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NONE			
16. SOCIAL SECURITY NO. NONE				17. INFORMANT WALDON STURMS, MIDLOTHIAN, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Dilatation 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) myocardial insufficiency (a), stating the underlying cause last, (c) 2 years				INTERVAL BETWEEN ONSET AND DEATH Sudden			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE WO McLane M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) WO McLane M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 1-24-61		22c. NAME OF CEMETERY OR CREMATORY BELINGTON CEMETERY	
22d. LOCATION (City, town, or country) BELINGTON, W. VA.				22e. LOCATION (City, town, or country) (State) Belington W. Va.			
23. FUNERAL DIRECTOR JULIUS RUNNER,				24a. REC'D BY REGISTRAR JAN 25 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

10010

RECORDS OF THE MEDICAL EXAMINER'S OFFICE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
072
CERTIFICATE OF DEATH
C0071

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 1 HR. 45 MIN.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRESAPTOWN	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL AND WARWICK AVES.				d. STREET ADDRESS 1 VAN METER APARTMENTS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) VIOLET		First H. Middle STUTLER Last		4. DATE OF DEATH Month JANUARY Day 12 Year 19 61			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JAN. 13, 1898	
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Ownhome		11. BIRTHPLACE (State or foreign country) INDIANA		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME JAMES TARR				14. MOTHER'S MAIDEN NAME MARGARET TARR			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Heart Corrupt Obstruction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension Arteriosclerosis Coronary Artery Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH Months							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Arteriosclerosis					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug 12 1961 to Jan 12 1961 , that (I) (we) last saw the deceased alive on Jan 12 1961 , and that death occurred at 8:45 P.M. from the causes and on the date stated above.							
22a. SIGNATURE [Signature]		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1/14/61			
22c. PHYSICIAN'S NAME (Type) DR. G. O. HIMMELWRIGHT		22d. ADDRESS 133 VIRGINIA AVE., CUMBERLAND, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF I-I7-61		23c. NAME OF CEMETERY OR CREMATORY Floral Hill Memorial Cem. Clarksburg, W. Va		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli				ADDRESS Cumberland, Md.		25a. REC'D BY REGISTRAR DATE JAN 17 '61	
				25b. REGISTRAR'S SIGNATURE [Signature]			

100051

CERTIFICATE OF DEATH

073

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may be required by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

073

CERTIFICATE OF DEATH

C0072

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. LENGTH OF STAY IN 1b 2 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Charles Middle Gordon Last Taylor				4. DATE OF DEATH Month January Day 28th , Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 25th, 1903	
9. AGE (In years lost birthday) 57 yrs.		IF UNDER 1 YEAR Months 57 Days 57 Hours 57 Min.		IF UNDER 24 HRS. Months 57 Days 57 Hours 57 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret.-Watchmaker				10b. KIND OF BUSINESS OR INDUSTRY Watchmaking			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME John Taylor				14. MOTHER'S MAIDEN NAME Mary Willison			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. 217-09-6866			
17. INFORMANT Mrs. Myra Taylor, 75 Broadway, F'bg. Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cirrhosis liver 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Portal Hemorrhage (c) 2 hrs. INTERVAL BETWEEN ONSET AND DEATH 2 hrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Dec 19 1960 to Jan 28 1961 that (I) (we) last saw the deceased alive on Jan 28 1960 , and that death occurred at 11:30 AM , from the causes and on the date stated above.							
22a. SIGNATURE John B. Davis, M.D.				22b. DATE SIGNED 1/30/61			
22c. PHYSICIAN'S NAME (Type) John B. Davis				22d. ADDRESS 2 Broadway, Frostburg, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-31-61		23c. NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park		23d. LOCATION (City, town, or county) (State) Frostburg, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE J. P. Durst				25a. REC'D BY REGISTRAR FEB 1 '61			
ADDRESS Frostburg, Md.				25b. REGISTRAR'S SIGNATURE Arthur S. Kline			

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

074

CERTIFICATE OF DEATH

00073

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 1 DAY d. NAME OF HOSPITAL OR INSTITUTION (If in hospital, give hospital name and street address) MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND d. STREET ADDRESS 14 HARRISON STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) MILDRED Marie THRASHER		4. DATE OF DEATH Month JANUARY Day 10 Year 1961		5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAY 18, 1917		9. AGE (In years last birthday) 43 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Kelly-Tire Co.				11. BIRTHPLACE (County & State, or foreign country) WEST VIRGINIA				12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME HENRY C. AUVEL				14. MOTHER'S MAIDEN NAME JACKIE WOTRING				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No.				16. SOCIAL SECURITY NO. 214-07-0957				17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple sclerosis DUE TO (b) Cerebral thrombosis with metastases to lung DUE TO (c) 6 months Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.																INTERVAL BETWEEN ONSET AND DEATH 6 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from Sept 1, 1960 to July 10, 1961 that (I) (we) last saw the deceased alive on July 10, 1961 and that death occurred at 9:54 P.M. from the causes and on the date stated above.																			
22a. SIGNATURE DR. B. SCHINDLER				22b. DATE SIGNED 1/14/61				22c. PHYSICIAN'S NAME (Type) DR. B. SCHINDLER				22d. ADDRESS 43 Greene St., Cumberland, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 1/13/61				23c. NAME OF CEMETERY OR CREMATORY Shaffertown Cemetery				23d. LOCATION (City, town or county) (State) Shaffertown, W. Va.							
24. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George				24a. ADDRESS Cumberland, Md.				25a. REC'D BY REGISTRAR JAN 16 '61				25b. REGISTRAR'S SIGNATURE Arthur S. Hume							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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MARYLAND

ALLEGY

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MEMORIAL HOSPITAL

EMERSON & WADSWORTH AVENUE

10 HARRISON STREET

MILFORD

THOMAS

JANUARY 10

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FEMALE WHITE

MAY 18, 1917

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WEST VIRGINIA

U. S. A.

REMY C. AUVIL

JACKIE WORTH

MEMORIAL HOSPITAL, GILBERTLAND, MD.

Handwritten notes in cursive script, mostly illegible.

DR. S. SCHWELER

SHILTONS Cemetery

SHILTONS, N. Y.

U. S. Army George Washington, Md.

SHILTONS, N. Y.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
075
CERTIFICATE OF DEATH
C0074

1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport rural		MARYLAND c. LENGTH OF STAY IN 1b 41 Yrs		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport-Rural	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D. 1		d. STREET ADDRESS R.D. 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Hazel Viola Trenum		First Middle Last		4. DATE OF DEATH Jan 30 1961 Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1904 Aug. 10, 1904		9. AGE (In years last birthday) 56 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) W. Va.	
13. FATHER'S NAME Frederick Evans		14. MOTHER'S MAIDEN NAME Elizabeth Dawson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT William M. Trenum-R.D. 1 Westernport, Md. Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 331X IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO (b) Hypertensive Vascular disease DUE TO (c) 10 yrs. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7-25-1960 to 1-30-1961 , that (I) (we) last saw the deceased alive on 12-5-1960 and that death occurred at 6:30 PM , from the causes and on the date stated above.					
22a. SIGNATURE Robert W. Bess Jr. M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1-31-61	
22c. PHYSICIAN'S NAME (Type) Robert W. Bess Jr. M.D.		22d. ADDRESS W. Va.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/2/61		23c. NAME OF CEMETERY OR CREMATORY Bloomington	
23d. LOCATION (City, town, or county) Bloomington				(State) Md.	
24. FUNERAL DIRECTOR'S SIGNATURE E. J. Boal		ADDRESS Westernport, Md.		25a. REC'D BY REGISTRAR Feb 3 '61 DATE	
				25b. REGISTRAR'S SIGNATURE Arthur J. H...	



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CERTIFICATE OF DEATH

00075

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 60 Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1200 Holland Street				d. STREET ADDRESS 1200 Holland Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) FORRIS		First AUSTIN		Last TRIPLETT		4. DATE OF DEATH Month January Day 10 Year 19 61	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH April 18, 1877	
9. AGE (In years lost birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Supervisor		10b. KIND OF BUSINESS OR INDUSTRY W.M. R. R.	
11. BIRTHPLACE (State or foreign country) Kerns, W. Va.		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Randolph Triplett		14. MOTHER'S MAIDEN NAME Sally Kittle	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mr. Shawell Triplett, Baltimore, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis lying cause lost. (c)		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchitis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 1/10		20g. (County) 1/10		20h. (State) 1961	
21. I certify that (I) (this hospital) attended the deceased from 1/10 to 1/10 , that (I) (we) last saw the deceased alive on 1/10 , and that death occurred at 2:00 PM , from the causes and on the date stated above.		22a. SIGNATURE Leo H. Ley Jr.		22b. DATE SIGNED 1/12/61		22c. PHYSICIAN'S NAME (Type) Leo H. Ley Jr.	
22d. ADDRESS Cumberland, Md		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/13/61		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park	
23d. LOCATION (City, town, or county) Cumberland, Md		23e. REC'D BY REGISTRAR 1/16/61		23f. REGISTRAR'S SIGNATURE Charles E. Hines		23g. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Md.	

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be filed with the funeral director, and completely filled in by the attending physician and completely filled in by the funeral director. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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077
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
00076

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Thurman Middle Ashford Last Twigg				4. DATE OF DEATH Month January Day 15 Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 5, 1901 59 yrs.	
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Blacksmith				9b. KIND OF BUSINESS OR INDUSTRY Railroad			
10a. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME George A. Twigg				14. MOTHER'S MAIDEN NAME Lillie Mae Bucy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 163X			
17. INFORMANT Mrs. Charlotte M. Twigg				Address Cumb. Md. 447 Goethe St.,			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatous DUE TO 163X Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) Carcinoma of Lung DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH 5 min 16 min			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that (I) (this hospital) attended the deceased from Oct. 1959 to Jan 15, 1961 , that (I) (we) last saw the deceased alive on Jan 15, 1961 , and that death occurred at _____ M, from the causes and on the date stated above.							
22a. SIGNATURE Clay E. Durrett				22b. DATE SIGNED 1/16/61			
22c. PHYSICIAN'S NAME (Type) Dr. Clay Durrett				22d. ADDRESS 236 Va. Ave. Cumberland, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 19, 1961		23c. NAME OF CEMETERY OR CREMATORY Davis Mem. Burial Park		23d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George				25a. REC'D BY REGISTRAR 202 Greene St. Cumberland, Md.			
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus				DATE JAN 19 '61			

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CERTIFICATE OF DEATH

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[Faint, mostly illegible text, likely a death certificate form with fields for name, date, and location.]

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DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00077

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 5 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CHARLES Middle C Last WALTERS				4. DATE OF DEATH Month 1 Day 17 Year 1961			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/9/89	
9. AGE (In years lost birthday) 71 yrs.		10. IF UNDER 1 YEAR Months 1 Days 17 Hours 19 Min.		11. AGE (In years lost birthday) 71 yrs.		12. IF UNDER 24 HRS. Months 1 Days 17 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret.-Flagman				10b. KIND OF BUSINESS OR INDUSTRY W.Md. R.R.			
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME ALBERT WALTERS				14. MOTHER'S MAIDEN NAME SOPHIA PRITTS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. 712-14-1592		17. INFORMANT CHART Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 334x DUE TO Hemiplegia due to Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO 2 days (c) INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from January 14, 1961 to January 17, 1961 , that (I) (we) last saw the deceased alive on January 16, 1961 , and that death occurred at 7:15 AM from the causes and on the date stated above.							
22a. SIGNATURE B. M. Schindler				22b. DATE SIGNED 1/17/61			
22c. PHYSICIAN'S NAME (Type) DR. P. M. SCHINDLER				22d. ADDRESS 43 GREEN STREET			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-19-61		23c. NAME OF CEMETERY OR CREMATORY Methodist Cemetery		23d. LOCATION (City, town, or county) (State) Mt. Savage, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE J. J. Frost ADDRESS Frostburg, Md.				25a. REC'D BY REGISTRAR JAN 23 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

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078

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
CERTIFICATE OF DEATH

1. Name of deceased: *John J. Smith*

2. Sex: *Male*

3. Age: *45*

4. Date of death: *12/15/1912*

5. Place of death: *Home*

6. Cause of death: *Heart disease*

7. Signature of physician: *John J. Smith*

8. Signature of registrar: *John J. Smith*

9. Date of registration: *12/15/1912*

10. Place of registration: *New York City*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

C0078

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 8/15/60		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 43 Westernport					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary				d. STREET ADDRESS 325 Maryland Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Sarah Middle Shaw Last White				4. DATE OF DEATH Month January Day 18 Year 19 61					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/9/1872			
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Barton, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME George Henry Shaw				14. MOTHER'S MAIDEN NAME Agnes Somerville					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT P. O. Box 599 Address Cumberland, Md. Allegany County Infirmary records.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocardial Degeneration 592X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary arteriosclerosis DUE TO (c) Chronic Nephritis								INTERVAL BETWEEN ONSET AND DEATH ? ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE/CONDITION GIVEN IN PART I (a) Senile Deterioration								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 8/15/60 19 to 1/18/61 19, that (I) (we) last saw the deceased alive on 1/18/61 19, and that death occurred at 10:25 P.M. M, from the causes and on the date stated above.									
22a. SIGNATURE James E. McLean				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 1/19/61			
22c. PHYSICIAN'S NAME (Type) Dr. James E. McLean				22d. ADDRESS 49 Greene St., Cumberland, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/21/61		23c. NAME OF CEMETERY OR CREMATORY Memorial Park		23d. LOCATION (City, town, or county) (State) Frostburg Md			
24. FUNERAL DIRECTOR'S SIGNATURE E. S. Boal				ADDRESS Westernport.		25a. REC'D BY REGISTRAR DATE JAN 23 '61			
				25b. REGISTRAR'S SIGNATURE Arthur E. Kneass					

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MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

080

Item 8 Film 279 1-15-61 et

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1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Beechwood Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JAMES Middle WHITEMAN Last WHITEMAN		4. DATE OF DEATH Month 1/5/1960 Day 19 Year 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/13/1874
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	9. AGE (In years lost birthday) 87 yrs. IF UNDER 1 YEAR Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John A. Whiteman		14. MOTHER'S MAIDEN NAME Jane a. Leatherman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Lonaconing, MD		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Degeneration Not specified as Rheumatic 422.1 DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO Chronic Myocarditis and Myocardia INTERVAL BETWEEN ONSET AND DEATH 10 Years 10 Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Influenza with Acute Bronchitis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec. 29, 1960 to Jan. 5, 1961 , that (I) (we) last saw the deceased alive on Jan. 2, 1961 , and that death occurred at 4 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Paul R. Wilson		22b. DATE SIGNED 1-6-61	
22c. PHYSICIAN'S NAME (Type) Paul R. Wilson M.D.		22d. ADDRESS Piedmont, W. Va.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1/8/1960	
23c. NAME OF CEMETERY OR CREMATORY Greens Cemetery		23d. LOCATION (City, town, or county) (State) Garret County, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHORN		25a. REC'D BY REGISTRAR DATE JAN 9 '61	
ADDRESS LONA CONING, MD.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE W.Va.		b. COUNTY Mineral	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 3hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Short Gap, W.Va.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital		d. STREET ADDRESS Rt. #1		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Harold R. Yokum		4. DATE OF DEATH I-2-61		Month Day Year 19 61	
5. SEX M.	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 16, 1907	9. AGE (In years last birthday) 53 yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Buff, Repair Air bags Tire Planta		10b. KIND OF BUSINESS OR INDUSTRY (Auto)		11. BIRTHPLACE (County & State, or foreign country) Petersburg W.Va.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Grant Yokum		14. MOTHER'S MAIDEN NAME Grace Hiser	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214-07-0896		17. INFORMANT Hester L. Harr	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Coronary Artery Disease (c) Coronary Artery Disease		INTERVAL BETWEEN ONSET AND DEATH 30 minutes		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Cumberland, W.Va.	
20f. (City or town) Cumberland, W.Va.		20g. (County) Mineral		20h. (State) W.Va.	
21. I certify that (I) (this hospital) attended the deceased from 1/2/61 to 1/2/61 , that (I) <input checked="" type="checkbox"/> saw the deceased alive on 1/2/61 , and that death occurred at 4:15P from the causes and on the date stated above.		22a. SIGNATURE Richard J. Williams		22b. DATE 1/2/61	
22c. PHYSICIAN'S NAME (Type) Richard J. Williams		22d. ADDRESS 122 S. Center St. Cumberland, Md.		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF I-5-61		23c. NAME OF CEMETERY OR CREMATORY Maple Hill Cem.	
23d. LOCATION (City, town or county) Petersburg, W.Va.		23e. REC'D BY REGISTRAR DATE JAN 9 '61		23f. REGISTRAR'S SIGNATURE Arthur S. Harr	
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		24b. ADDRESS Cumberland, Md.		24c. DATE JAN 9 '61	

Mineral

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Short Gap, W.V.

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RE. 1

Wormley Hospital

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1-2-51

Yokum

H.

Harold

April 12, 1907

USA

Petersburg, W.V.

White Plains

Bull, Repair Air

(Auto)

Grace Hiser

Grant Yokum

21-07-088 Hester E. Hest

4:10

111 E. Center St., Cumberland,

Richard J. Williams

Petersburg, W.V.

Maple Hill Cem.

1-5-51

Funeral

James T. Scarphill Cumberland, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
082
CERTIFICATE OF DEATH
C0081

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland Maryland		c. LENGTH OF STAY IN 1b 3 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Flintstone Maryland					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) BLANCHE First ARBUTUS Middle YONKER Last				4. DATE OF DEATH Month January Day 9 Year 19 61					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/18/1885			
9. AGE (In years last birthday) 75 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Flintstone, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Leroy Chaney (D)				14. MOTHER'S MAIDEN NAME Nancy Christie (D)					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Chart					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Acute left ventricular failure DUE TO (b) Coronary arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. none (c) Coronary insufficiency; extensive myocardial fibrosis								INTERVAL BETWEEN ONSET AND DEATH 5 days ? ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASES LISTED IN PART I (a) Uremia Diabetes mellitus								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from 1/6 19 61 to 1/9 19 61 , that (I) (we) last saw the deceased alive on 1/9 19 61 and that death occurred at 6:55 P M, from the causes and on the date stated above.									
22a. SIGNATURE Dr. S.M. Jacobson, M.D.				22b. DATE SIGNED 1/9 61					
22c. PHYSICIAN'S NAME (Type) Dr. S.M. Jacobson, M.D.				22d. ADDRESS 50 Pershing St. City					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/12/61		23c. NAME OF CEMETERY OR CREMATORY Pleasant Grove Meth. Cem.		23d. LOCATION (City, town, or county) (State) Near Cumberland			
24. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Md.				25a. REC'D BY REGISTRAR JAN 16 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

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CERTIFICATE OF DEATH

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